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THE PHILOSOPHICAL ASPECTS OF DEATH IN CONTEMPORARY MEDICINE

The contemporary medicine is the domain of science and human practice that develops very intensively and multidirectionally. It harnesses in its frames the latest technical equipment and refined microbiological processes. It creates encouraging perspectives for human being seeking for long-life but, simultaneously, creates new dangers and threats. However, it cannot manage one problem to the present day – namely, the problem of death. The death concerns each person without exceptions. The death belongs to the problems dealt by philosophy as well. In medicine the problem of death assumes particular forms. In medicine, I have an impression, death is very diligently hidden.

The genesis of the fact can be found at the beginning of medical students' education. In the Library of Poznań Medical Academy there is a very few philosophical works and critical analyses of philosophy come chiefly from the sixties. The Library Staff asked for books concerning death reacted with astonishment. In the very respectful institution either there were not such books or they remained unidentified. The similar situation was in the reading-room, after all day by day provided with the reams of journals. In a way, the Library of medical Academy became the center of immortality where death is not allowed to enter.

Going further, one can notice that the perspective physicians learn above all practical and technical means of health restoring. In the studies schedule there is no place for

considerations regarding death which do not fit the policy of the studies. The humanists grieve for it, but these grievances are becoming widespread among the representatives of medical circles as well. In addition, the situation is more complicated by the fact that the major part of medical students and physicians dismiss philosophy in general. They think of philosophy as too abstract and vain divagations, very often self-contradictory (or even contrary to reason), and – the worst of all – without any use in practice. This attitude was confirmed by the very outstanding surgeon, Prof. T. Butkiewicz, who wrote: “(...) the surgeons ascribe to the name of philosophy the negative connotation.” (1) He supplemented this with very important sentence: “(...) by the physicians who think too simply and primitively the humanism has something mawkish in itself and is the relict of romanticism. (...). But there is no true medicine without humanism, what remains then is only spiritless, not too high craft practiced not by masters but by medical apprentices.” (2)

The strong thanatophobia deepens in the course of medical practice. The physicians' activity chiefly aims at the improvement of patients' standard of living, keeping them alive at all, as this is the case on very difficult hospital wards. That is why death scandalizes, ruins the regular efforts of medical staff and knowledge and practice gained strenuously, through many years, became insufficient. In the field of physicians activity the full domination is impossible – this power has to be shared with the ruthless enemy the death is. Moreover, death shatters their personal aspirations and ambitions connected with curing the given “scientific case”. Just for this reason the death is for physician a destructive event, the more so it dangerously reminds him of his “personal” death which inevitably will come.

Usually physicians of different specialties, surgeons and anaesthetizers – the last by profession setting the situation of thanatomimesis, inquired about death issues become very embarrassed. They commonly hide the problem deeply because they are helpless about it. Certainly they lack accurate language that could express their doubts. Every one of them has his own, inner little graveyard that is visited by him only in loneliness and silence. That is the way in which death is surrounded by double sanitary cordon in medicine: the first one is the cordon of ignorance, the second – the tight cordon of silence. What comes in my mind here is the consolation attempt undertaken by Epicurus in antiquity. He used to say that death does not concern us because when we are there is no death and when there is death there is no us any longer. So we don't meet death at all. The similar situation is in medicine: till the patient is alive he exists for a doctor and is of interest to him. When the patient is dead, he turns into the subject of failed hopes passed to the funeral services and darks of oblivion.

Then, what is death?

To answer this question the best thing be to give the precise definition used in medicine. Because the considered issue is highly problematic and does not embrace only the frames of medicine, the inert logical form is not able to handle the again new problems provided by dying. The necessity of such definition seems then to be unquestionable, although it is a very difficult question, for some people even insoluble. “Such definition of death that would satisfy to the same extent philosophers, theologians, lawyers and physicians does not exist. Yet day by day the new facts appear which let us gain the complete certainty that the demise took place.” (3) And what is at stake this time is not the fear to be buried alive, hysterical fear, that unleashed in France in seventeenth and eighteenth century, influencing the development of last wills and security means. At that

time the places where probably dead are to be supervised were not only postulated, but created in Germany to “(...) gain the complete certainty that the demise took place. These first funeral homes were called: *vitae dubiae azilia* (asylums of questionable life) or more roughly: *obituaria* (place of dying)”(4).

Today there is a common belief, between both theoreticians and practitioners dealing with medicine, that death does not consist on one act, but is a step by step time process having a lot of traits. The moment, time point of death is rather a fiction: very useful and practical, but only fiction. That is why authors tackling these problems give different description of death. L. V. Thomas distinguishes the following kinds of death: genetic, quantum, functional, systematic, seeming, relative and absolute (tissue). (5) P. Ramsey distinguishes: clinical death, physiological death, death of organs and death of cells. (6) A. Ostrowska identifies: clinical, brain and cellular death. (7) Lungs, heart and brain are ones of the most important body organs. Their triad functioning is the base for the instrumental life: moreover, they are interdependent. Generally applied definition, accepted by majority of physicians, although not without criticism is so called Harvard definition of death. It says that human being dead when: “does not respond to external stimuli, when it does not move, when there are not reflexes and the EEG curve is flat (assuming that toning medicaments were not used or it did not come to hypothermia.” (8) Presently one of the most reliable criterion of human being’s death is the braindeath. This definition proves correct as to the vast majority of standard cases. There is, however, the large margin where it is insufficient.

The brain is extremely sensitive to anoxia and even several dozen of seconds is enough for some of its parts to atrophy. One can try rescue brain (and so the human being as well) till some moment, after which pathological changes in brain become irrevocable to such extent that later on only vegetative life, without awareness is possible. In spite of flat EEG curve the lower part of brain, phylogenetically oldest and answerable for vegetative processes can work. So the human organism can still work, exist – simply vegetate – with no chance to recover personal individuality. This state can be sustained long, especially when supplemented by very effective technical and chemical devices. Who, or what do we face then? Undoubtedly living organism, but whether still a human being? Human being reduced to organ stock? This situation is very accurately rendered by outstanding oncologist – J. Bréhant: “(...) question that is startling and full of torment: whether the man lying in front of us, naked one, inert, holed with tubes, needles, switched on the current, is it still a sick? Is he still alive? Or is he dead?” (9) It is the more perplexing, the more – as the same author wrote - “We can keep in the state of artificial survival a man, who lost his awareness, as long as we want”. (10) For this kind of situations one has coined special labels such as: “he defunct, but being in the state of artificial survival”, “the defunct, but sustained with artificial means”, “death artificially sustained”, “death in suspense”, “technical life”. (11)

The other definitions and criteria of death can be of any use. There is, so called, “ontological argument” saying that braindeath changes the human being’s status – if he does not have representative for people personal individuality, he is neither a person nor human being any longer. (12) The other, cognate argument holds that braindeath destroys the possibility of interhuman communication forever, so such a man is already death. Successively, according to utilitarians when one can not achieve happiness nor help others to do it, he is death and useless.

The braindeath problem often occurs together with the problems of artificial life-maintaining, taking still alive and good-working organs for transplantation and the issue of euthanasia. It seems that there is a very interesting question when one can be separated from life maintaining equipment if it is obvious that he will not regain awareness and autonomy and will not be the human being in the full sense of the word. Such question is the other, maybe softer, version of the issue when one can let somebody die, resigning from expensive immortality. Because machines and medical equipment are only to be in service of helping life, supporting it in critical moments, but can not replace life. The follow-up of resignation from the help of the equipment is *de facto* the death of man, so it dangerously resembles euthanasia, at least the passive one.

The analogous problems can be observed with respect to reanimation and treatment of patients that are in the last phases of incurable, deadly diseases. Stopping of dying man's reanimation depends on usual and unusual means. Unusual means are means used with justified hope that the state of a patient can be improved, but at the expense of additional pain, expenditures and troubles. The Catholic Church basing on the statement made by pope Pius XII holds that there is no duty of applying unusual means to keep human being alive. The medical deontology perceives the issue in similar manner, allowing cure stopping (but not stopping of nursing) with respect to people in a helpless state. Both standpoints permit the "relinquishment" but in any case they put up with an active interference and speeding the process doomed to end with soon death. Church is of such opinion because of its absolutist approach to human life that is sacred. Physicians, however, are fettered by Hippocratic oath saying that "I will not give anybody - even asked - lethal poison, nor I will advise it". (13) The same oath says in other place: "I will employ medical measures according to my possibilities and talents to the sick's advantage, defending them against damage and harm". It allows a physician during his practice with dying people that can not be cured to enlarge and change doses of analgesic medications and drugs to mitigate pain even if it will advance the moment of death. The pain exhausts and kills as well. The medical ethics restrains enough to avoid giving such a large dose that would produce one-time and ultimate effect. Physicians move about on narrow and steep path dividing life and death.

The issue is much more complicated as far as transplantation is concerned. There is a danger that death definition can be freely interpreted to the profit of organ's taker. Therefore the party concerned, namely physicians from transplantation staff should not take part in the consultations deciding about patient's death. The doctor from donor's staff should not take part in the consultation as well, because different medical procedures could be established concerning sick persons with irreparable brain damage being only potential but not factual donor. It could result in medicine case. Much more heated controversies and disputes are set up by the problem of euthanasia. Its definition adopted by the Dutch Society for Voluntary Euthanasia and a lot of similar organizations reads: "Euthanasia is effective deprivation of life at somebody's own request". (14) The mere wording does not tell anything that this deprivation is done because mercy, to avoid much more exasperating and hardly bearable pain. That is humanitarian action, revealing the deep respect to the other person and helping to remain this part of humanism dignity that was left by disease. As R. Fenigsen wrote in his book, only Holland is the country where "compassion for the human suffering is more important than obsolete laws and any taboos; where freedom of choice was appreciated, of choice to have at one's dis-

posal one's life and deciding about one's own death." (15) When one takes into consideration these pure and noble intentions euthanasia seems to be a quite lucid problem, almost necessary way of evincing humanism.

The euthanasia problem is so convoluted, full of niceties, misunderstandings and false beliefs that often is associated with the ancient Sparta where sickly infants were turned away or with nazi physicians and their stillborn ideas. However, the results of polls concerning euthanasia, made from thirties, that is from the time when first Societies for Voluntary Euthanasia were established, are striking. To avoid confusion it is worth adding that members of these societies don't side with slaying helplessly sick, but only with allowing them to die without unusual and technical means. They do not also side allowing to die to those people who want to die. So, the poll made by British Poll Institute showed that 68% of inquired approve euthanasia. (16) In 1938 in USA it was approved by thousands of doctors (80% of inquired, according to Gallup Institute) and hundreds of preachers and rabbis. (17) The same institute in 1973 received approbation of over half from inquired population. However "The poll done in 1986 (...) showed that in Holland 76% supported voluntary euthanasia and that 77% declared themselves for involuntary euthanasia, without patient's agreement and knowledge." (18) However, in Poland the situation is slightly different. In poll done by CBOS in December 1988 30% of investigated approved euthanasia, but almost 50% disapproved it. (19) These are high numbers, especially in respect with physicians. When anonymity and informal atmosphere is assured, they willingly admit having employed euthanasia both with the consent of patients and without it. Connected with that there is a spectacular and difficult to moral evaluation case described in French press a few years ago. Some doctor invented a particular device: "(...) Thanatron, a machine to self-dependent suicide: soporific portion of penthotal before giving the finishing stroke of the solution of potassium which immediately stops the work of heart after reaching it." (20) For some people this is a step before placing slot-machines on streets serving people who become disgusted with life and want to die hygienically, professionally and up to a minimal standard. So it seems justified to study in details the issue of euthanasia from legal point of view taking into account mentality changes and social needs. So far in Polish criminal law euthanasia is a crime.

According to many authors dealing with the issue of death, including doctors as well as philosophers, sociologist and anthropologist there is theoretical and practical necessity of creating a branch that would embrace not only euthanasia but death on the whole. The great deal of this problem is taken by bioethics, but there is a range of problems concerning death which are not gripped by it. This task cannot be completed only by medical circles and cooperation with humanists is necessary. Even the name introduced by a philosopher, Francis Bacon in XVII th century arouses negative connotations that cannot be easily removed. So, the other labels are suggested, for instance "aghatanasia" or "bene mori" (P. Ramsey), "euthanalogy" (T. Kielanowski), "medicothanasia" (J. Bréhant). The others would like to create a science branch dealing exclusively with death. Neglecting very narrow labels like: "methaphysics of death", "ontology of death" or "phenomenology of death" rather more general issues would be at stake, such as: "philosophy of death", "thanatology", "anthropology of death" (L. V. Thomas) or some interdisciplinary "science of death" (J. Bréhant).

ENDNOTES

1. Butkiewicz T., *Moja filozofia chirurgii (My Philosophy of Surgery)*, PZWL, Warszawa 1974, p. 6.
2. Ibidem, p. 65.
3. Szawarski Z., the review of american journal *Bioethics Reporter*. In: "Studia Filozoficzne" ("Philosophical Studies") No 7 (248), 1986, p. 170.
4. Ariés P., *Man and Death* (original title *L'homme devant la mort*) quoted from polish translation done by E. Bąkowska, PIW, Warszawa 1992, p. 392.
5. Thomas L. V., *Dead Body. From Biology to Anthropology* (original title *Le cadaver. De la biologie a l'anthropologie*) quoted from polish translation done by K. Kocjan, Wydawnictwo Łódzkie, Łódź 1991, pp. 8-10.
6. Ramsey P., *The Patient as Person*, quoted from polish translation done by S. Łypacewicz, Instytut Wydawniczy PAX, Warszawa 1977, p. 85.
7. Ostrowska A., *Śmierć w doświadczeniu jednostki i społeczeństwa (Death in the Experience of Individual and Society)*, PAN, Instytut Filozofii i Socjologii, Warszawa 1991, p. 62.
8. Quoted from Z. Szawarski "Wprowadzenie – dwa modele etyki medycznej" (Introduction – Two Models of Medical Ethics. In: *W kręgu życia i śmierci. Moralne problemy medycyny współczesnej (In the Circle of Death and Life. Moral Problems of Contemporary Medicine)*. Ed. by Z. Szawarski, Książka i Wiedza, Warszawa 1991, pp. 12-3.
9. Bréhant J., *Thanatos. The Sick Person and Doctor in the Face of Death* (original title *Thanatos. Le malade et le devant la mort*) quoted from polish translation by K. Sudolska, Wydawnictwo ANCHER, Warszawa 1993, p. 131.
10. Ibidem, p. 130.
11. Ramsey P., *The Patient as Person*, p. 101.
12. Green M., Winkler D., *Brain Death and Personal Identity*, quoted from Z. Szawarski, the review..., p. 170.
13. Pieces of Hippocratic oath from Z. Szawarski, *Introduction – Two Models...*, p. 9.
14. Quoted from R. Fenigsen, *Eutanazja. Śmierć z wyboru? (Euthanasia. Choice of Death?)*, Wydawnictwo "W drodze", Poznań 1994, p. 46.
15. Ibidem, p. 9.
16. Quoted from T. Kielanowski, *Problem niepotrzebnego cierpienia (The Problem of Unnecessary Suffering)*. In: *In the Circle of Death and Life...*, p. 164.
17. Ibidem, p. 164.
18. Fenigsen R., *Euthanasia...*, p. 48.
19. Quoted from A. Ostrowska, *Death in Experience...*, p. 67.
20. From "Le Point", 11 XII 1993. Reprinted in "Forum", 9 I 1994 under the title *The Murderer or Benefactor*.