

# Reading the Signs of Death: A Theological Analysis

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## ABSTRACT

Determinations of death made by physicians are clinical judgments, but nonetheless judgments involving metaphysical realities, the passing of persons from this life. Current controversy about the validity of neurological criteria for determining death suggests the need for careful study of anthropological reasoning as well as medical data. This article proposes charity and wisdom as a theological context for the use of such neurological criteria. These concepts clarify what it means to relieve burdens to patients, family, and caregivers and to promote organ transplantation while refusing the direct killing of patients. A question remains whether neurological criteria suffice or should be related to signs in other parts of the body. This article defends in part the argument of Edward J. Furton for the validity of neurological criteria but argues that at least in some cases signs of life and death from other bodily systems should be regarded.

**P**ERHAPS IT IS OBVIOUS that physicians should make the determination of death, especially when a person dies while in a state of unconsciousness. Because physicians possess the practical knowledge and technical skill, society rightly entrusts them with this task, while establishing a legal and moral-cultural framework for performing it. On the other hand, physicians can observe only the external signs that death has occurred. Whether one gives a common philosophical definition of death as the separation of the soul from the body or a more theological one, such as the expiration of the breath of life, death marks the loss of integrative wholeness in a person whose interior life is never fully revealed through those external signs. So the physician's work makes a judgment of metaphysical, and not merely physical, relevance.

To read magisterial pronouncements regarding the use of the brain-death criterion, one might assume that the Catholic Church simply defers to physicians on these judgments. For example, Pius XII taught that

the role of medicine is “to give a clear and precise definition of ‘death’ and the ‘moment of death’ of a patient who passes away in a state of unconsciousness,” and to judge particular cases by that standard, following civil law in cases of doubt.<sup>1</sup> On the other hand, the Pope charges physicians to uphold certain presumptions, both medical and anthropological in nature, specifically, that “human life continues for as long as its vital functions—distinguished from the simple life of organs—manifest themselves spontaneously or even with the help of artificial processes.”<sup>2</sup> Taken together, these statements mark the beginning of a papal magisterium that asks for the integration of medical and anthropological understandings of human death in a specific context: the unconscious person on life support.

Just over forty years later, after great medical progress had refined techniques for transplanting vital organs and the means of evaluating the condition of a patient’s organs, including the brain, John Paul II gave a qualified endorsement to the theory of brain death and, along the lines established by Pius XII, sketched the Church’s role in reading the signs of human death. According to current medical knowledge—assuming that the death of the brain ruptures the physical integrity of the body—the Pope taught that the criterion for ascertaining brain death, “if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology...[and suffices] for arriving at that degree of assurance in ethical judgment which moral teaching describes as ‘moral certainty.’”<sup>3</sup> Thus, a medical decision that a death has occurred rests on an anthropological judgment that the irreversible cessation of the whole brain constitutes a sign of death, and not just a clinical definition of death, but the unique event that

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<sup>1</sup> Pius XII, “Address to an International Congress of Anesthesiologists” (November 24, 1957) in *Conserving Human Life*, ed. Russell Smith (Braintree MA: Pope John Center, 1989), pp. 315-16, 318.

<sup>2</sup> *Ibid.*, p. 318; see also p. 316.

<sup>3</sup> John Paul II, “Address to the 18th International Congress of the Transplantation Society” (August 29, 2000), n. 5, reprinted in *National Catholic Bioethics Quarterly* 1/1 (2001): 89–92.

is the death of an individual person. Should that medical/anthropological judgment turn out to be wrong, as some have argued, we would no longer use brain-death criteria with moral certainty.<sup>4</sup>

Although the Church defers to medical judgment regarding the clinical definition of death and the determination of when patients meet that definition, as Pius XII has taught, she does not simply accept whatever definition is offered, much less a lax application of morally certain definitions. John Paul II tasks the Church with a discussion about how clinical definitions of death actually reveal the death of the person:

With regard to the parameters used today for ascertaining death—whether the “encephalic” signs or the more traditional cardiorespiratory signs—the Church does not make technical decisions. She limits herself to the Gospel duty of comparing the data offered by medical science with the Christian understanding of the unity of the person, bringing out the similarities and the possible conflicts capable of endangering respect for human dignity.<sup>5</sup>

Current controversy among ethicists and health-care professionals makes the moral justification for determining death by the neurological criterion seem less certain than when John Paul II endorsed it. It seems altogether reasonable, however, that a person might die in an unconscious state while on a ventilator, and that the person’s body would provide signs of death even though some organs desirable for transplantation remain viable.

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<sup>4</sup> See the well-known work of D. Alan Shewmon, summarized with a bibliography by William E. May in *Catholic Bioethics and the Gift of Human Life* (Huntington IN: Our Sunday Visitor, 2000), ch. 8. A number of philosophical arguments against the theory of brain death are found in *Beyond Brain Death*, ed. Michael Potts, Paul A. Byrne, and Richard G. Nilges (Dordrecht, The Netherlands: Kluwer Academic Publishers, 2000). Clinical difficulties are enumerated in K. G. Karakatsanis and J. N. Tsanakas, “A Critique on the Concept of ‘Brain Death,’” *Issues in Law and Medicine* 18/2 (2002): 127-41.

<sup>5</sup> John Paul II, “Address to the 18<sup>th</sup> International Congress of the Transplantation Society,” n.5.

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Therefore, the Church should press medicine for a more complete reading of the signs of death. In her own health-care institutions, the Church should guard against any trend to declare death prematurely in order to facilitate the transplantation of organs, as well as any trend to abandon the dead-donor rule entirely.<sup>6</sup> Lastly, following John Paul II's judgment, she should study carefully the medical data and anthropology needed to show how the body's organs and systems reveal the passage into death.

COVENANT, CHARITY, AND WISDOM: A THEOLOGICAL CONTEXT

The Church's involvement in the healing arts stems from her mission to reconcile humanity with God. This mission is set within the context of God's covenant of salvation, including the Ten Commandments, which communicate the moral foundation of man's part in this covenant. The determination of death and the moral issues of withdrawing life support and of organ transplantation raise the issue of killing and bring us face to face with the fifth commandment. Any set of criteria for determining death that turns out to be unsound or is wrongly applied can lead to actions that end the life of the person and constitute killing. Moreover, the intentional use of unsound criteria or the abuse of protocols is gravely sinful. It is important to recall that the covenant and commandments were established out of divine love for humanity. As a guide for conscience, the substance of the Ten Commandments is perceptible by natural human reason regarding fundamental human needs, such as trust that one will not be killed. And most significantly, these commandments are not a law-based code of ethics but rather instructions in the art and practice of loving. Christ revealed their correspondence to the law of loving God and of loving

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<sup>6</sup> Byrne et al. have noted that even some literature on criteria for brain death "have tended to confuse evidence that someone is about to die with evidence that he is already dead." See Byrne et al., "Brain Death—The Patient, the Physician, and Society" in *Beyond Brain Death*, p. 28. Parul R. Mistry advocates replacing the dead donor rule with informed consent in "Donation after Cardiac Death: An Overview," *Mortality* 11/2 (2006): 182-95. See also Robert D. Truog, "Organ Donation without Brain Death?" *Hastings Center Report* 35/6 (2005): 3.

one's neighbor as oneself.<sup>7</sup>

But when patients lie unconscious without any reasonable hope of recovery, the command not to kill human life appears to offend both charity and mercy. Charity seems to require withdrawing care, especially when medical professionals clearly recognize that the patient is irreversibly unconscious and willing to donate vital organs. On the other hand, keeping the commandments promises to establish charity, especially in cooperation with the power of the Holy Spirit "at work in their letter."<sup>8</sup> Here charity seems to require refusing actions that are intended to cause or hasten death. Thus, the problem for the patient revolves around loving God by preserving one's life against the temptation to end it (when writing an advance directive), while seriously considering what means are proportionate for avoiding death and whether to donate all or part of one's body for the benefit of others. The problem for professionals revolves around loving patients by using their skills and resources to prevent needless suffering and, if possible, to heal them.

In practice, charity becomes complicated quickly. Christian tradition has developed many "mediating principles" to which professionals may turn to refine moral reasoning about a case or policy. The same reasoning, however, should be animated by charity, and one teaching in particular, called the *ordo amoris*, or "order of love," attempts to sort out human relationships in light of the two greatest commandments and, by extension, the Ten Commandments.<sup>9</sup> Briefly, the order of love is:

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<sup>7</sup> See the basic account of the commandments in *Catechism of the Catholic Church*, §2052-74.

<sup>8</sup> *Ibid.*, §2054.

<sup>9</sup> St. Augustine introduces the problem by asking, "Should we love all equally or some more than others?" and St. Thomas Aquinas develops a systematic treatment in the *Summa theologiae* II-II, q. 27. See St. Augustine, *De doctrina christiana* I.26-29; and Benedict Ashley, O.P., *Living the Truth in Love* (New York NY: Alba House, 1996), pp. 443-44.

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- Love of God above all things. Even when one does not sense the love and presence of God, one is willing to suffer and die rather than break God's covenant through sin. Keeping the fifth commandment in end-of-life situations entails a patient's willingness (though not desire) to suffer rather than consent to be killed, and for professionals it means conscientious objection to killing another and a willingness to modify, perhaps change radically, one's path of professional advancement or one's employment.
- Love of self as regards to one's own salvation. One is willing to suffer and die rather than sin not only for love of God, but also for love of self. For a patient, self-love might mean choosing and empowering caregivers who will act in one's best interest, and communicating that although disproportionate means need not be taken, one asks for basic care, even in an irreversibly unconscious state. Self-love requires a professional to refrain from killing even if civil law permits it and institutional policy promotes it.
- Love of neighbor as oneself. One loves the salvation and well-being of one's neighbor more than one's material possessions and even one's own body. This love motivates one to donate one's organs if it can be determined that one has indeed died. It also entails a willingness (though not a strict obligation) to forgo disproportionate means in order to relieve caregivers and family members of a prolonged dying process. This love would motivate professionals and institutions to expend resources in life support for the good of a patient, even for those who cannot or will not give much in return. This love treats a corpse, even a "brain-dead body," with the respect due to the body of a person.

Some may object that this conception of love and law are religious and irrelevant to public discourse and thus society's health care. Yet just as the content of the Ten Commandments appears across cultures, the struggle to articulate priorities in human love across cultures recognizes "sins" against love, that is, acts and intentions that undermine personal integrity and social relationships. Moreover, scientific study bears out a complementary

ordering of love. Drawing on contemporary sociobiology, Stephen Pope has shown how this order of love rests on an evolved biological tendency to care for others, beginning with those closest in kinship and proximity.<sup>10</sup>

Both the patient who is willing to preserve one's life but is open to organ donation, and the clinician who stringently seeks means of determining death while refusing unsound criteria and euthanasia for transplantation, respond to natural human imperatives to love. The impulse to derive criteria for determining death can be properly understood as a way to avoid failure in charity.

The wisdom literature found in sacred scripture provides one excellent source for recognizing the ways in which we fail charity. While a part of divine revelation, this literary tradition often appeals to the enjoyment of this world but ridicules the foolish ways in which we typically pursue enjoyment. In doing so, this literature recognizes patterns of moral reasoning that lead to human destruction. While we obviously find nothing in sacred scripture of clinical importance about the failure of single organs related to the death of persons, we discover positive and negative attitudes toward death that still persist today. In light of the possible abuse of morally sound protocols and advance directives, consider the warning in the Book of Wisdom against "inviting death":

It was the wicked who with hands and words invited death, considered it a friend, and pined for it, and made a covenant with it, because they deserve to be in its possession, they who said among themselves, thinking not aright: "Brief and troublous is our lifetime; neither is there any remedy for man's dying, nor is anyone known to have come back from the nether world. For haphazard were we born, and hereafter we shall be as though we had not been; because the breath in our nostrils is a smoke and reason is a spark at the beating of our hearts, and when this is quenched, our body will be ashes and our spirit will be poured abroad like unresisting air..." (1:16-2:3, New American Bible).

Although this particular pattern of thought might not often pass through the

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<sup>10</sup> Stephen J. Pope, "The Order of Love and Recent Catholic Ethics: A Constructive Proposal," *Theological Studies* 52/2 (1991): 255-88.

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minds of many people, making it inappropriate to call them “wicked,” it does describe a materialistic and relativistic approach to life and death that could gain traction in the construction of advance directives or in actual cases of brain death. The patient’s condition is irreversible, he is going to die anyway, we cannot stop it; would it not be better if death came sooner, so we may “pour abroad” whatever is left? To employ this type of reasoning in the determination of death fails the charity communicated in the commandments, rooted in human nature, and compatible with human biology.

Criteria for brain death are incorporated into a larger judgment and decision process that potentially expresses the charity proper to human relationships. The Church relies on medical judgment to read the physical signs of personal death, but relates this medical judgment to philosophical and theological judgments about human anthropology. The current debate about the legitimacy and use of brain-death criteria focuses on two areas in which Church moral tradition can help patients, families, and medical professionals address issues concerning the determination of death of a person on life support: the abuse of brain-death protocols and the refinement of the theory itself. First, by relying on the medical expertise and experience of Catholic health-care institutions, the Church should continue to develop morally sound protocols that recognize the goods of ceasing interventions rendered futile by the death of the patient, and of facilitating organ transplantation while respecting the freedom and integrity of patients. Second, the Church should continue to develop her theological and philosophical tradition in an attempt to clarify the signs of death in a human person.

ABUSE OF BRAIN-DEATH CRITERIA

It would be wrong to discount the theory of brain death simply because it is a response to ethical issues arising from the creation and use of life support and transplant technology. The theory should be judged according to the truth of medical data and sound anthropology. On the other hand, the connection between the theory and its social benefit, despite appeals to



social charity, lends itself to a utilitarianism of the sort foreseen in wisdom literature. Recounting the history of the development of the brain-death theory, Rev. Nicanor Austriaco observes that an early draft of the Harvard criteria for brain death advanced the new theory on purely utilitarian grounds, namely: “great need for tissues and organs of, among others, the patient whose cerebrum has been hopelessly destroyed, in order to restore those who are salvageable.”<sup>11</sup> The final report, however, surpassed this utilitarianism and articulated the benefits of the theory for the dying patient, families, professionals, and other patients needing their share of medical attention.

Thirteen years later, the Carter administration justified this redefinition of death primarily in terms of patient and family benefit and secondarily in terms of organ transplantation. According to the President’s Commission charged with studying the issue, the two main reasons are “the need both to render appropriate care to patients and to replace artificial support with more fitting and respectful behavior when a patient has become a dead body,” and “the increasing realization that the dedication of scarce and expensive intensive-care facilities to bodies without brain functions may not only prolong the uncertainty and suffering of grieving families but also preclude access to the facilities for patients with reversible conditions.”<sup>12</sup> Thus, the theory of brain death and its clinical use are justified primarily by an appeal to charity that includes but does not emphasize the possibility of organ donation.

There is good reason to believe that this presumption of charity often

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<sup>11</sup> Nicanor Austriaco, O.P., “Is the Brain-Dead Patient Really Dead?” *Studia Moralia* 41/2 (2003): 284, citing the draft of “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 (August 5, 1968): 337-40.

<sup>12</sup> President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death* (Washington, D.C.: U.S. Government Printing Office, 1981), cited by Austriaco, p. 286.

enough gives an appearance of legitimacy to declarations of death on people who are not dead. First, the widespread promotion of brain-death criteria to clinicians who lack the necessary degree of expertise might bring social pressure to use them anyway.<sup>13</sup> Second, even after charitable reasons have been articulated, the demand for transplantable organs will not cease to create powerful incentives to employ unsound criteria for determining death or to misuse sound criteria. Indeed, those charitable reasons may simply be a form of lip service.<sup>14</sup> Finally, the use of brain-death protocols is easily leveraged into a larger movement to promote euthanasia and physician-assisted suicide.<sup>15</sup> By promoting legitimate instruments, such as

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<sup>13</sup> E. M. Wijdicks, "Current Concepts: The Diagnosis of Brain Death," *New England Journal of Medicine* 344/16 (April 19, 2001): 1215-21. Wijdicks observes that the expertise for declaring brain death may be lacking in smaller hospitals. The conclusion that the promotion of brain-death criteria may create an expectation and pressure to use them is my own.

<sup>14</sup> Consider the following quote from bioethicist Arthur Caplan: "There are lots of efforts to bridge the growing gap between demand [for] and supply [of organs]. We have to be very careful that we don't make people think that we don't have their best interests in mind and are just going to use them to get their body parts." Quoted in Rob Stein, "States Revising Organ-Donation Law," *Washington Post* (April 4, 2007), p. A1, accessible at: <http://www.washingtonpost.com/wp-dyn/content/article/2007/04/03/AR2007040302062.html>.

<sup>15</sup> A useful account of the spread of the movement for euthanasia and physician-assisted suicide is available from Life Tree, at <http://www.lifetree.org/timeline/index.html>. This site places in evidence Last Acts, a coalition of about 120 national health and consumer groups funded by the Robert Wood Johnson Foundation and others for the laudable goal of improved end-of-life care. Although the "Last Acts" literature does not often speak of euthanasia or physician-assisted suicide, clear advocacy occasionally arises. Consider the keynote speaker, Ira Byock, M.D., at the 1997 Last Acts conference: "Among the general public...there is anger, especially regarding care at life's end. This is most dramatically apparent in the groundswell of support for legalizing physician-assisted suicide. The anger is not surprising, but in response, Americans are looking for someone to blame. In this we should be wary." "Dying Well in America: What Would Success Look Like?" address in

advance directives, as well as controversial changes in professional standards, such as withdrawing nutrition and hydration when the patient can still assimilate them, this movement creates conditions favorable to euthanasia coupled with the donation of organs.<sup>16</sup> This account of law and culture is not to suggest that making an advance directive regarding withdrawal and donation is necessarily wrong. Indeed, it can be an act of authentic charity. Given the cultural context in which brain-death criteria have been developed and are now used, the Church would be unwise simply to defer to medical professionals in the use of those criteria. In fact, the appropriate use of brain-death criteria may support the pro-life cause if it allows society to distinguish a gravely ill person from a corpse moved by life-support technology, and thus erodes one aspect of the argument that euthanasia is necessary to prevent the overuse of health-care resources.

#### WHICH SIGNS OF DEATH?

This aid to the pro-life movement and ultimately to patients, families, and caregivers depends, of course, on the truth of the brain-death theory. Does the death of the brain represent the death of the entire person? Discussions continue at the highest levels of the Church and among Catholic ethicists in light of John Paul II's qualified endorsement of brain-death criteria. Since the Pope gave that endorsement, doubts persist whether adequate signs of brain death can be found and, if they can, whether the death of the brain is indeed the death of the person. For example, Karakatsanis and

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Washington D.C. (October 1997), accessible at: [http://web.archive.org/web/20020130025947/www.lastacts.org/la\\_ala/levdying.htm](http://web.archive.org/web/20020130025947/www.lastacts.org/la_ala/levdying.htm). Aside from the questionable assertion of a "groundswell of support" for physician-assisted suicide, these words intimidate to promote an agenda.

<sup>16</sup> Regarding advance directives, see criticism of a widely used living will, "Five Wishes," in Edward J. Furton, "A Critique of the Five Wishes," *Ethics & Medics* 30/3 (2005): 3–4. Regarding the coupling of euthanasia and organ donation, witness the recent controversy over North Carolina's advance directive bill SB 1046, in which irreversible unconsciousness and dementia become grounds for the withdrawal of life support and basic care.

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Tsanakas argue that the clinical condition “brain death” cannot be adequately defined, because it is impossible to develop a series of tests complete enough to determine the loss of total brain function. Furthermore, patients who meet brain-death criteria and who theoretically can no longer sustain the body’s integration have been found to maintain the integrity of important systems and functions, including hypothalamic-endocrine functions, a stable hemodynamic state, cellular uptake of chemical markers, and electrocerebral activity even after cerebral bloodflow has ceased.<sup>17</sup> On the other hand, some claim that the integrity of these systems without a living brain is not the sign of a human soul and therefore that the person has died.<sup>18</sup>

But even if medical professionals could design a series of tests adequate to determine brain death, the debate whether the death of this organ signifies the death of the person seems to require some judgment from the Church, or at least some anthropological development. Progress here would enable the acts of charity, especially the vital organ donation so much desired in modern society. In an article mentioned previously, Austriaco contributes to this effort by proposing a systems approach to death that helpfully emphasizes the molecular level but unnecessarily downplays the relevance of organs within the body’s system. Austriaco criticizes Edward J. Furton’s argument in favor of the theory of brain death—that the death of the whole brain signals the death of the person because the human soul is rational and thus requires the brain as “the seat of cognitive life.”<sup>19</sup> In Austriaco’s view, Furton is forced “to conclude that the critical functions that need to be lost for [total brain death] to obtain are

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<sup>17</sup> See Karakatsanis and Tsanakas, “Critique on the Concept of ‘Brain Death,’” 128-30, and Robert D. Truog, “Is It Time to Abandon Brain Death?” *Hastings Center Report* 27/1 (1997): 29–37.

<sup>18</sup> Edward J. Furton, “Brain Death, the Soul, and Organic Life,” *National Catholic Bioethics Quarterly* 2/3 (2002): 467-70.

<sup>19</sup> Furton (2002) p. 467.

those functions that are important for cognition.”<sup>20</sup> Austriaco’s interpretation is plausible, but not necessary. Furton’s premise does not require this conclusion if the intellective soul animates the brain in all its functions, including the lower functions. In that case, a functioning brain stem alone is still a functioning though disabled organ, and thus still the sign of an intellective soul whose cognitive abilities are hampered by the brain’s disability. Then the death of the brain signals the separation of the soul from the body. Furton’s argument for the solidity of brain-death criteria, therefore, could remain within the standard justification, namely, that brain death is the loss of the organ that integrates the body.

Austriaco then questions an underlying assumption of the brain-death theory—that a single organ mediates the union of soul and body—by asking the following: if the brain, and therefore the person, dies, but other systems continue, what single organ accounts for the integrity of that system?<sup>21</sup> By pushing the logic of brain death to this extreme, Austriaco emphasizes the dependency of organs on each other within the body’s system. This point does not decide the debate, for one might respond that the functioning of a certain bodily system is not a sign of human presence. It depends on which system and which organs.

One way forward in this debate may be through the concept of “relation.” What relation do individual organs have to each other and to the person as a whole? A basic account of the concept of “relation” provides for a subject possessing some quality or activity that can be directed to something else, a term, that accepts what is given, and a ground, the gift.<sup>22</sup>

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<sup>20</sup> Austriaco, p. 300.

<sup>21</sup> Austriaco here continues to criticize Furton’s argument that, as he understands it, “the [brain dead] patient’s body is alive because it is animated by a subhuman soul,” yet Furton nowhere refers to a “subhuman soul” and states that he does not try to answer the question of what type of soul animates a brain-dead body. See Austriaco, p. 300, and Furton (2002), pp. 467-69.

<sup>22</sup> See, for example, Joseph Owens, *An Elementary Christian Metaphysics* (Notre Dame IN: Univ. of Notre Dame Press, 1985), pp. 179-85, and a different

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So medicine might proceed by defining what each vital organ and each system give to the other with a view to interpreting signs of integrative unity and of the presence of a human soul. At the same time each vital organ and system must be related to the person as a whole, identifying what it contributes to the whole. For example, lungs relate to the heart by delivering oxygen to the blood; heart relates to the body by delivering oxygenated blood throughout; brain relates to the person by integrating the body as a whole and enabling higher functions. This approach is clearly not new, but is rather a continuation, perhaps a synthesis, of existing positions. Relating the individual organs and systems of the body to each other and to the whole person leads one back to the centrality of the brain, though without discounting the significance of other organs and systems, all of which support the highest activities of an intellectual soul. Such a relational approach could yield “clusters” of signs coming from different organs and systems and allow for more accurate determinations of death, in some cases in advance of the failure of vital organs that could be transplanted. On this theory, the whole-brain-death criterion and the cardiopulmonary criterion each sharpen the clinical definition and determinations of death, though neither is presumed a sufficient condition.<sup>23</sup> Furthermore, some criteria might be more evident in certain sets of circumstances. For example, the brain-death criterion might generally be more effective in cases of head trauma than of disease.

This proposal is not necessarily at odds with Austriaco’s emphasis on the “molecular network” of the body, whose disintegration at some point signifies the death of the person. Austriaco concludes that “death would coincide with the disintegration of the molecular network that makes up the body as a whole,” that is, after sufficient cessation of respiration and

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construal of the same elements by Bernard Lonergan, *Insight: A Study of Human Understanding* (London UK: Darton, Longman and Todd, 1958), pp. 490-97.

<sup>23</sup> Winston Chiong provides a philosophical realist justification for this approach in “Brain Death Without Definitions,” *Hastings Center Report* 35/6 (2005): 20–30.

circulation.<sup>24</sup> But is it not also the case that these molecules are part of organs and systems and relate to each other through them? It seems that attention should be focused on the way in which these molecules signify the life of the person through organs and systems, with the relation of the heart, lungs, and nervous system to the brain, and its relation to them, being the fundamental relations considered.

#### THE CHURCH'S ROLE

Although the theory of brain death developed in a utilitarian context, its criteria for determining death, if sound and rightly applied, form a basis for acts of charity. The Church contributes to this social charity by guarding against the abuse of these criteria in a society that has, at least provisionally, accepted them. More important, the Church tests strategies for determining death by analyzing them in light of its anthropological tradition. In carrying out both these tasks, the Church takes great interest not only in theoretical discussions of brain death, but also in the particulars of individual cases.

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<sup>24</sup> Austriaco, p. 305.