

Personhood, Medicine, and American Society

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REFLLECTION AND DEBATE AROUND THE QUESTION “What is a person?” has a long and continuous history in Western thought. For centuries, it has been a core preoccupation of philosophy, and it is also central to the matters with which the social sciences deal. The term “person,” as distinguished from “human being,” or “individual,” has often been used to suggest that “man” is not “a biologically fixed and innate sum total of drives, . . . a lifeless shadow of culture patterns,” or “an object whose properties can be definitively described, as is the case with inanimate things” (Fromm 1949, 17, 247). This notion of person refers to the fact that the human being has a dynamism of its own: active, evolving, transforming inner qualities that continually, progressively, and somewhat mysteriously move him/her through a cumulative process of becoming and unbecoming.

If there is such a dynamic in human life, it is because, at any given moment, man is never what he is called to be. And if this is so, it is because, in a sense, human existence is suspended between what exists in the here and now, and what is still to come. . . . Man remains, at least partially, an enigma for himself. We do not completely know exactly what we mean when we use the words

“man” or “person” (Ladrière 1972, 167) (translated from the French original).

This sense of not knowing “exactly what we mean” has contributed to the coining of the neologism “personhood,” and has generated a great deal of discussion within American society about “the problem(s) of personhood.” Our perplexity about something so basic to our individual and collective identity as how we define a person, a human being, our humanity, our human existence, and what meaning we ascribe to them seems to have attained societal proportions. In both implicit and explicit forms, publicly as well as privately, and in many institutional spheres of American life, major questions have arisen about our cultural conceptions of personhood, and about what their implications are for how we relate to our individual selves, and to multiple others.

John Ladd (1982) suggests three reasons why the term “person” has suddenly become such a popular one among philosophers engaged in ethical discussion. First, the term is nonsexist; John Locke’s “man” unfortunately has no English gender-free equivalent to “Mensch,” “homo,” or “anthropos.” Second, “person” is preferred by philosophers as a way to avoid a Cartesian mind-body dualism. Finally, Ladd notes, “person” serves as a placeholder in the juridical sense of “the subject of rights and duties.”

Personhood Questions in Modern Medicine

Personhood-centered questions are occurring in the realms of family, economy, polity, education, science, technology, and religion with regard to a wide and varied array of matters. Foremost among the institutional sectors of the society in which personhood issues are accorded the most serious and sustained attention is the area of health-illness-medicine. Research and care situations, hospital, practice, and laboratory settings, bioethical and medico-ethical milieus, commissions, committees, and advisory boards, courts and legislatures, and the mass media are all involved in this complex convergence of medicine and personhood. It is a convergence made dramatic through the post-Nuremberg apprehension about a society’s capacity to “exterminate”

personhood using medical means in the process. It is also a convergence that is timely, involving medical technology's newly developed capability to "confer" or to "extend" personhood. For all its complexity, this concern with personhood is focused on a priori questions and concrete decisions.

A variety of biomedical phenomena and clinical conditions have become foci of questions concerning personhood, and of the bearing of personhood on issues that involve medical discernment, decision-making, and action. These include fetal development and abortion, human genetics, *in vitro* fertilization and other forms of reproductive technology, organ transplantation, mental retardation, brain disease and certain chronic and progressive neurological disorders, states of senility, dementia, as well as coma, terminal illness, and "brain death."

These discussions about personhood center on what is currently known and not known, and what can and cannot be done medically regarding conception, embryonic development, birth, our genetic makeup and inheritance, our central nervous system, the human brain, the implantation and transplantation of living parts of ourselves (genes, cells, tissues, and organs), and our mortality. It is interesting to note that the a posteriori questions of medico-ethical decisions—the longer-term consequences of what medicine does or does not do in these matters—is seldom at the heart of personhood questions. Thus, application of the technological innovation of amniocentesis stirs debates at the convergence of medicine and personhood; today's maturation of the nation's first full cohort of Down's syndrome-afflicted newborns does not.

Within this framework, the beginning and the end of life—"emerging life, and life that is passing away" (in Sissela Bok's phrasing before the personhood conference), our "natality" (Hannah Arendt's term invoked by Hans Jonas)—and our mortality, particularly in connection with abortion, on the one hand, and withholding or terminating life-sustaining treatment, on the other, the most copious and deeply felt considerations of personhood have been elicited. Although such considerations have been felt throughout all ages and societies, in American society they have been acted upon, most often, privately—within the family and kinship group. Modern scientific medicine, its technology and its institutions, move these questions and their resolution to ever-larger and more public forums.

The womb and the brain are important symbolic, as well as anatomic, loci of these personhood-linked discussions. Gender is also a key element in the abortion and personhood issues, both because of the biological relationship that exists between the body of the woman and the developing life of the fetus, and because of the social and political claim made by feminist advocates for abortion that a woman has the right to decide what should be done with her own body. The heart and lungs, along with the brain, are involved in the deliberations that are occurring over the traditional criteria for pronouncing death, on the basis of irreversible cessation of heart and lung functions, and the more recently developed means for diagnosing and declaring death on the grounds of the loss of all functions of the brain. There is a more than neurological and metaphoric sense in which the new, brain-oriented "definition of death" implies a fundamental shift in our cultural premises about where the bodily site of our fullest and highest personhood lies. Hospital intensive care units (ICUs) (neonatal, medical, and surgical) are among the chief physical settings in which such serious questions of nascent and expiring life and personhood arise. In the minds of medical professionals and the lay public alike, ICUs have become empirically and emblematically associated with advanced modern medicine in its most powerful, life-saving and life-maintaining, and its most depersonalizing and dehumanizing, forms.

Although these problems of personhood with which our society is grappling are significantly interwoven with modern medicine, they are not engendered by it in a cause-effect way. If they were, then we would expect that wherever in the world the science and technology of medicine had reached a point of development comparable to present-day American medicine, personhood would be at issue in the same fashion and to the same degree that it currently is in our society. But, as Willy De Craemer (1983) observes, there is no society other than our own in which problems of personhood have become so acute, pervasive, and also public. What this kind of singularity means is not a simple matter that can be easily deciphered. However, the fact that our society has entered a period of economic and moral retrenchment is significantly influencing the process. In this connection, an examination of some of the conceptual language and recurrent themes that characterize how personhood issues in American society are being expressed in and through medicine is illuminating.

The Language and Themes of Personhood

One of the striking features of these "medical" discussions concerning personhood is that philosophers and jurists, together with physicians and biologists, are the most influential shapers of the discourse, and the most vocal participants in it. This is partly a consequence of the fact that "bioethicists" have been actively involved in personhood questions related to biomedicine and have produced a vast literature on the subject. "Bioethics" is a term coined sometime in the 1960s to refer to the rise of concerned interest in ethical and existential issues associated with modern biology and medicine, and to the emergence of a new, interdisciplinary field of inquiry and action focused on these issues. The primary intellectual and professional groups that have contributed to bioethical discussion, research, writing, and action have been moral philosophers (ethicists), physicians, biologists, lawyers, and, recently, economists (Fox 1974).

In matters pertaining to personhood, as with numerous other bioethical topics, the perspective and terminology of the philosophers (drawn heavily from the tradition of analytic philosophy) have predominated. Legal concepts and vocabulary have become increasingly important in the bioethical consideration of personhood, partly as a consequence of the growing number of relevant cases that have found their way into the courts. Although in their decisions on these cases (principally concerned with abortion and the status of the embryo, fetus, and newborn, and with treatment and nontreatment in a variety of extreme medical situations) the courts have been disinclined to explicitly use personhood language and criteria, they have repeatedly done so implicitly, as Leonard Glantz (1983) points out.

In addition to medicine, philosophy, and the law, a number of social movements have shaped the ways in which the ongoing discussions of personhood are conceptualized and phrased. These include groups that are organized (pro and con) around such issues as women's rights, population control, abortion, and euthanasia. They are concerned with the implications of how the person and his/her humanity are viewed, for the special problems and goals to which their particular movement is dedicated.

However varied the form and content of the many different considerations of personhood and medicine may be, they are unified

around one predominant theme: individualism. The majority of those currently writing and speaking about personhood in this context start with a highly individual and individuated conception of the human person. The autonomous self-awareness of the individual and his/her self-reliance, independence, and freedom are consistently emphasized, along with the uniqueness, worth, and dignity of every single person. These individualistic attributes are not only presented as personal virtues, and good social values, but as entitlements. They are frequently expressed in "rights" language: the right to autonomy, the right to privacy, the right to decide for one's self, the right to control one's own body and psyche, the right to life, and the right to death. It is an ambiguous language without a grammar adequate to clarify conflicting meanings and claims. Thus, whole categories of persons (infants, women, patients, the mentally ill, the retarded, the impaired, the comatose), and also incipient persons (fetuses) and departing persons (the dying) are separately treated, in terms of their own, distinctive, self-oriented, individual rights.

A second, albeit subdominant theme that permeates the discussions of personhood concerns "connectedness": the interrelationship and the interdependence of individuals and of groups of individuals. To be a person who is truly and fully human, this perspective on personhood underscores, is to recognize, as Margaret Farley (1982) puts it, our "relationality" and "other-relatedness." Hans Jonas insists that it starts with our acknowledgment of the obligations we have to others, and our binding commitment to them through time. It entails taking responsibility for our own actions and being accountable for them, especially for how they affect others. But something more than a stern, impersonal sense of duty and accountability enters into these relational dimensions of personhood. Self-giving, mutual respect, trust, concern, empathy, compassion, patience, and reverence are all core elements. And crucial to this "otherness" of personhood is the willingness both to care for others and to allow others to care for us. The significant others who are part of the "living system of social relationships" that are vital to becoming a person and to being a person not only include "our brothers and sisters" but, in our Judeo-Christian religious tradition, "our strangers," and "even our enemies" (De Craemer 1983). Underlying these parameters of personhood, and emerging from them, is a conception of community and society, the human condition, and, as De Craemer

adds, "the vaster-than-human," that is at once self-transcending and the *sine qua non* of selfhood.

The theme of individualism prevails over that of connectedness in the way in which medicine-associated problems of personhood are being raised. The individualistic claims about the essential features of personhood are the ones more frequently and strenuously made. They are asserted in a fashion that attaches supreme importance to the desires and dictates of individual conscience. Other, more interpersonal forms of authority—including, and especially, the authoritative influence of the family and family relationships over our actions—are more ambiguously and waveringly invoked. Yet, as Victor Lidz (1982) perceptively notes, there is also a "touchy, insecure" quality present in the discourse about individualism: palpable tension and uncertainty over how to link the "selfness" of persons with their caring and communal interrelatedness.

Concerning Competence

The nature of this gap, and the deep dilemmas that are involved in trying to bridge it, are exemplified by the issues around "competence" that have developed in the practice of medicine. Certain kinds of patients—their capacities, status, rights, and medical predicament—are at the center of these issues: infants and children in general and very sick ones in particular, the severely mentally retarded or mentally ill, those afflicted with Alzheimer's disease ("senile dementia"), individuals who live in what Irving Cooper (1982) terms "the fourth world" of neurological affliction, and patients in irreversible coma. The most difficult and painful problems concerning such patients occur when they reach a point in their terminal illness, or their comatose state, where the question about whether to initiate or continue life-prolonging treatment on their behalf becomes an acute matter. During the past decade, the courts as well as the patients themselves, their families, and the medical professionals involved in their care have been increasingly faced with the question of whether "non-treatment decisions" ever can or should be made in this type of situation and, if so, under what circumstances, by what process. When patients are not physically, intellectually, and/or emotionally competent

to accept or decline life-sustaining treatment, who should make such a decision, in what forum, according to what criteria?

Beginning in 1976 with the case of *Karen Quinlan*,¹ the courts have repeatedly affirmed that “the constitutional right of privacy” allows all patients, incompetent as well as competent, to refuse life-supporting treatment that is not curative or life-saving. In so doing, the courts have explicitly defined each patient, no matter what his or her physical or mental state, as a person of “intrinsic human worth” and “human dignity” with the inviolable and nondelegable right of “individual free choice and self-determination.”² Within the framework of this “right to decide one’s own fate” perspective on personhood, the courts have argued that such decisions must be based on “the complexities of the singular situation” of the patient, “viewed from the unique perspective” of that person, rather than on what a majority of “reasonable persons” would or would not do in such circumstances.³ But how can one know what a particular patient who cannot competently articulate his/her choices would decide? The courts have chosen to deal with this awesomely difficult question through the “subjective test” of the “substituted judgment.” In effect, this is a proxy judgment, made on the basis of determining “with as much accuracy as possible the wants and needs of the individual involved” (Annas 1977, 11).

It is precisely at this juncture, where someone must be authorized to decide what another individual would have decided on his or her own behalf, that one of our deepest societal dilemmas over personhood lies. How can we reconcile the overriding individualism of our cultural conception of the human person with the ways in which our personhood (including the recognition of our autonomous rights) is interconnected with, and dependent on, our relationship to others? This issue has become paramount when the courts have been asked to rule on *who* should decide about medical treatment or nontreatment for an incompetent patient. Should it be the patient’s family? His or her physicians? Especially close, kinlike friends? But then, which relative? Which physician? Which friend? And who can, or should, speak for the growing number of persons in our society who are isolated or disconnected from most recognized forms of relationships, such as the

¹ *In the Matter of Karen Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

² *Superintendent of Belchertown v. Saikewicz*, 370 N.E. 2d 417 (Mass. 1977).

³ *Ibid.*

lone elderly, or "street people" like "bag ladies" or "vent men"? Should a group of persons, like a hospital ethics committee, rather than a designated individual, make these life-and-death decisions? Or is it the court itself that must ultimately be concerned with "such questions of life and death . . . that require . . . detached but passionate investigation and decision," and that involve the "morality and conscience of our [whole] society"⁴ along with the inalienable rights of every one of its individual members?

The root of the problem lies in the cultural difficulty we presently have in recognizing any person or persons, any relationship, or any group as so intimately and responsibly part of an individual's life and identity that they can be accepted as trustworthy spokespersons for the individual's needs and choices, convictions and commitments. What Victor Lidz (1982) has gone so far as to call this "metaphysical gap" in our society's sense of community is vividly expressed in a statement made by the attending physician for Mr. Earle N. Spring, whose case was heard in 1980 in the Massachusetts courts.⁵ This case involved a senile 78-year-old man, residing in a nursing home, who was suffering from end-stage renal disease which was being treated with dialysis. Mr. Spring's son (his temporary guardian) and his wife petitioned the probate court for an order allowing the dialysis to be terminated. The case proved to be a complicated one, involving a first judgment, followed by a revocation of that judgment, and the entering of a second judgment by the probate judge, and a subsequent hearing of the case by the appeals court. Looking back and reflecting on the decision-making process, Dr. Leroy Shear (1981), Mr. Spring's physician, had this to say:

I believe that the court's remarkable mismanagement of this case—the delays, the cost, and the suffering felt by all persons involved—proves beyond a doubt that these issues cannot be decided through the legal system as it now exists. . . .

Let me also say that I have become very humble about my own ability to decide for others whether to stop dialysis. . . . Throughout the legal imbroglio with Mr. Spring, I talked with most of our patients about who should decide to stop dialysis if they themselves could not decide, and what decision they would want made for them. The responses . . . varied so much that I doubt that anyone

⁴ Ibid.

⁵ *In the Matter of Earle Spring*, 1980 Mass. Adv. Sh. 1209, 1214 (1980).

can decide for anyone else. Many patients have expressed anger that anyone . . . would have the audacity to make the decision for them. One patient said she would stop dialysis if she became like Earle Spring, but expressed concern that her husband would not let her stop. Others said they never would want to stop, but they wondered whether their spouses would “pull the plug.” Some expressed concern that a judge or doctor would have the power to stop their life. . . . [But] when asked who should decide, these patients did not know. . . . The dilemma was best summarized by a few elderly but very bright and alert patients, who said they could not decide because they do not know what it is like to be like Earle Spring. They also voiced concern that if they did become demented, they no longer would be able to express their feelings. How can judges, or anyone else, substitute judgment for demented patients without knowing what it’s like to be demented themselves?

“Doctorhood” and “Nursehood”: Professional Competence in Personhood

The questions of competency and personhood in medicine that have come to the forefront in our society are not confined to the status and situation of the patient. Reciprocally, they also concern “doctorhood” and “nursehood”: the intellectual and technical qualities, and the attitudes, values, and perspectives that the men and women who do these forms of medical work bring to it. They are the very questions that made Dr. Shear “humble about [his] ability to decide for others.”

Over the course of the past decade, a new professional and public awareness of the incidence of “burn-out” among physicians and nurses has developed. “Burn-out” is a term loosely and colloquially applied to the state of medical professionals whose work and ardor about it have been adversely and chronically affected by a complex mix of tension, fatigue, frustration, anger, sadness, and/or ennui engendered by the work itself.

Underlying the identification of these phenomena, the terminology used to identify them, and the growing interest in preventing and remedying them is the recognition that medical work entails more than the mastery of scientific knowledge and technical skills, that it deals with some of the most basic and ultimate aspects of the human condition:

The conception of human beings, their birth, survival and growth, their physical, emotional and intellectual capacities and development, sexuality, aging, mortality and death are core foci of health, illness, and medicine, as are the quality of their lives, and some of the significant forms of pain, suffering, accident and *Angst* that human beings experience. . . . The experience of illness and the practice of medicine also summon up critical problems of meaning—fundamental questions about the “whys” of pain, suffering, the limits of human life, and death, and about their relationship to evil, sin and injustice (Fox 1979, 12–13).

Because medicine is “serious” in these ways, the personhood of physicians and nurses is deeply, continually, and often stressfully involved in the work that they do. Their personhood is more than a humanistic decoration. It is an inherent part of their technical competence and judgment fundamental to their capacity to recognize, understand, identify with, respond to, and accept the personhood of their patients and of the members of their patients’ families.

Secularization and Consensus

But why is the American tradition of individualism and its relationship to community and personhood in our society now so acutely problematic? And why has this problem opened onto metaquestions like: What is life? What is death? When does life begin, and when does it end? Is there such a thing as “wrongful birth,” or “wrongful life”? And is it better not to have been born at all, than to have been born with severe “defects”? What accounts for the fact that medicine has become a societal center of these questions, which are as moral and metaphysical as they are biological and scientific? And what is the significance of the fact that such issues have shifted their “location” from the private and privatized professional domains of the society in which they have traditionally been handled to the arena of public affairs where, to an increasing extent, they are being dealt with by courts, legislatures, and commissions?

“Why this is happening, and what this means,” Willy De Craemer (1983) cautions, “are no simple matters about which facile formulations can or . . . should be made.” But he goes on to suggest that one of

the major developments contributing to the “problems of personhood,” and the ways that they are manifesting themselves in our society, may be “the kind of secularization of . . . our distinctive religious tradition . . . that we have undergone”:

What I am alluding to is a process of reductionism that “thins down” and “flattens out” the meaning of the individual and person, family and kinship, sex and sexuality, self-giving and sharing, kindness and sympathy, caring and mercy, equality and justice, mutuality and solidarity, communion and community, responsibility and commitment, birth and life, joy and suffering, mortality and death, so that they are progressively stripped of both their primal and their transcendent significance, and of their relationship to the common good, the human condition, and the vaster-than-human.

. . .

In the past, the individualism of our cultural tradition was embedded in such a larger framework—at once political, moral and religious. . . . But somehow, in recent years, our individualism seems to have sprung loose from that broader framework. . . .” (De Craemer 1983).

There is an element of paradox in the fact that one of the notable consequences of this process of secularization is that it seems to have contributed to the heightened presence of moral and religious issues in the public sphere. In the face of the “publicization” and secularization of “collective conscience” matters, the scientific, technological, and human condition import of medicine and its advances has acquired greater societal significance. To a striking degree, medicine has become one of the “primary symbolic media” through which our society is publicly struggling with basic questions of value and belief (Fox 1977, 21). The central place that personhood and medicine problems now occupy in the public forum is a focal part of this development.

Watching how these issues are being played out in the public arena, especially in the polity, raises a number of questions about whether—in a society like ours with its principles of pluralism, separation of church and state, and governance under law—it is possible or desirable to “try and reach a formalistic agreement about what we mean by ‘person’ that would be binding on us all.” If so, what ought to be “the form and substance of that agreement,” and what are the most culturally appropriate and socially effective means of arriving at such an agreement? “If not, how should our society deal with the problems of personhood?” (Swazey 1983).

Types of Consensus

Our current efforts to resolve uncertainties and negotiate conflicts over medicine-associated issues of personhood through public discussion and the deliberation of courts, legislatures, and commissions have generated two opposing types of difficulties. On the one hand, attempts to crystallize and enforce a consensus through explicit legal statements and rulings about personhood or personhood criteria have stirred up more controversy than they have settled. Certainly, this has been the case with the U.S. Senate Bill 158, introduced by Senator Jesse Helms on January 19, 1981, which declares that "the Congress finds that present-day scientific evidence indicates a significant likelihood that actual human life exists from conception . . .," and goes on to reinterpret the Fourteenth Amendment to cover all human life including the fetus *in utero*. The bill evoked passionate disagreement over its constitutionality, over whether science can provide an answer to the question of when human life begins and a developing embryo becomes a person, and over whether such a question "must remain a matter of moral or religious values" (National Academy of Sciences 1981). Physicians, scientists, jurists, the clergy, philosophers, as well as United States senators and representatives were drawn into passion-filled hearings and debates, along with spokespersons for a variety of health, religious, labor, women's, and civil rights groups, and advocates for movements like Planned Parenthood and Right to Life, in ways that reopened and exacerbated the pro- and anti-abortion conflict in our society. A revised version of this bill (S.2148) was subsequently introduced by Senator Helms that omits "the appeal to scientific evidence to support congressional fiat," and "combines sections of S.158 with a number of strict prohibitions on federal funding of abortion." On October 15, 1981, Senator Helms arranged "to get the bill calendared in the Senate, meaning that it [could] be called up at any time without having to go through the committee process" (Segers 1982).

On the other hand, the kind of consensus about personhood and medicine questions that is reached by less confrontational, more diplomatic and intellectualized political and legal means is likely to be problematic because of the issues it plays down, eschews, or rules out. When such matters come before national or presidential commissions, for example, the "interest-group liberalism" that is structurally

built into their composition significantly contributes to the possibility that they will arrive at "consensus conclusions which avoid many of the questions that caused the creation of a commission in the first place":

Every commissioner represents a constituency. . . . This iron law of presidential appointment exemplifies what political scientist Theodore Lowi, in *The End of Liberalism*, called "interest-group liberalism": representatives of major sectors of American society participate, collectively, in arriving at consensus on policy. . . .

A man who has served on several [presidential] commissions said, "You know who you're supposed to represent as soon as you see who the other commissioners are. The commissioners are a deliberate cross-section of people with lines into other people. But even if you're a delegate, you try to relate to broader interests, including the general public's and the President's" (Popper 1970, 56).

It is this sort of democratic process, and the sublimations and omissions, as well as compromises that it involves, that gave some of Richard McCormick's associates on the Ethics Advisory Board the positive (albeit erroneous) impression that he was "good at public policy discussion because he [left] his personal religious convictions out of it" (McCormick 1983.)

But it is through what Dorothy Nelkin (1983) terms the "technicalization" of issues that characteristically takes place when questions like those of personhood go to courts, commissions, and specially appointed boards and committees, even more than through their "democratization," that the "reduction" and neutralization of their controversial social, moral, and religious implications generally takes place:

As these diverse institutions seek to resolve disputes, they invariably seek technical grounds to justify their decisions. The courts and the various administrative bodies called upon to develop acceptable principles that will help to resolve moral disputes have generally approached them by trying to extend the scientific method, and to find somehow a "truth" among conflicting claims. Indeed, despite the ethical and social bases of disputes involving questions of personhood, efforts to resolve them often reduce to a technical debate. The powerful moral, social or religious scruples that underlie positions adopted by parties to such disputes seldom become the subject matter of public debate. . . . (Nelkin 1983).

Defining Death: The President's Commission

The report issued by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death* (1981), exemplifies the form in which this narrowing of the problem typically occurs and the way in which the social, moral and religious issues that it involves are relegated to technical categories. Its opening three sentences state that "death is the one great certainty"; that it is "the subject of powerful social and religious rituals and moving literature"; that it is "contemplated by philosophers, probed by biologists, and combatted by physicians"; and that it is "taboo in some cultures, [and] preoccupies others." But in the very next sentence, the report swiftly moves on to assert that it will only explore a "small corner of this boundless topic," by addressing a question that "is not inherently difficult or complicated. Simply, it is whether the law ought to recognize means for establishing that the death of a human being has occurred." The body and bulk of the report deals with the use of heart-lung and brain criteria for the determination and pronouncement of death and with a detailed consideration of the role that the law, along with medicine, might play in developing and enacting a definition of death compatible with "advances in biomedical knowledge and refinements in technique." The major conclusions and recommendations of the report are: "that recent developments in medical treatment necessitate a restatement of the standards traditionally recognized for determining that death has occurred"; that "such a restatement ought preferably to be a matter of statutory law," at the state rather than at the federal level, and that it should be a uniform statute; that "the 'definition' contained in the statute ought to address general physiological standards rather than medical criteria and tests"; and that it should be constructed around the conception of death as a "unitary phenomenon which can be accurately demonstrated either on the traditional grounds of irreversible cessation of heart and lung functions or on the basis of irreversible loss of all functions of the entire brain."

The commission itself recognized that what it called "defining death" was a narrowly operationalized concept as signaled by its consistent use of quotation marks around the words "defining" and

“definition.” Although the membership of the commission and its staff was composed of philosophers and social scientists, as well as physicians and lawyers, and its witnesses also included theologians and clergy, the report did not deal with the broader social, cultural, ethical, or religious significance of death, or with its relationship to the definition and meaning of human life and the human person. Rather, it asserted that it was proper that the death statute it recommended “rest on secular foundations” and “not purport to dictate religious beliefs.” The Commission officially acknowledged that the statute it proposed would “have implications for secular legal and medical conduct with respect to the dead while permitting accommodation of religious views and practices.” However, it steadfastly rejected the notion that the new brain-based standard to determine death might connote a fundamental cultural shift in what is considered to be the at-once physical and symbolic locus of a “self” that is truly alive and human: in a sense, the seat of the soul.

The commission’s report ends with an allusion to “the attention paid in recent years to ethical issues in decisions to forego treatment of *dying*—but still living—patients,” and states that it will address itself to this matter in a subsequent report. But in its proceedings, and in the introductory and concluding pages of its report, the commission not only insisted that “determination of death” issues and “allowing to die”/non-treatment issues should be kept “separate”; it also implied that emphasizing the fact that both sets of questions “arise from common roots in the society,” and showing how they are interconnected though “distinct,” would “obscure and exaggerate the difficulties of framing policy.”

The Courts

On one level, “framing policy” this way, by analytically and empirically isolating out the most technical and functionally specific medical and legal aspects of defining death, focusing on those and dissociating them from the larger life and death and personhood questions of which they are a part, is both professional and practical. It draws upon the specialist expertise of the commission (or the committee or board, as the case may be), and it facilitates the formulation of decisions, conclusions, and recommendations. But as Dorothy Nelkin (1983) points

out, this process does not lead to principles that will resolve the social, moral, and/or religious uncertainties and conflicts that underlie the ostensibly technical issues:

Lacking the evidentiary bases to create acceptable technical definitions of personhood, and avoiding the fundamental questions at stake, government institutions and commissions have failed to settle moral disputes in any lasting manner.

Although the courts have dealt with medicine-related personhood matters more directly, and in the broader framework of the legal concepts of "person," "personality," "status," and "privacy" (Curran 1983), they have also felt obliged to assert that they have "no competence to resolve" some of the deepest, ultimate questions that issues of personhood entail. This is especially apparent in cases concerned with abortion, the fetus, "the defective newborn," "wrongful birth," "wrongful life," or where the non-initiation, refusal, or termination of medical treatment are involved:

We are on the threshold of new terrain—the penumbra where death begins but life, in some form, continues. We have been led to it by medical miracles which now compel us to distinguish between "death," as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not.⁶

We need not resolve the difficult question of when life begins. When those trained in the respective disciplines or medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary at this point in the development of man's knowledge is not in a position to speculate as to the answer.⁷

Whether it is better not to have been born at all than to have been born with even gross deficiencies is a mystery more properly to be left to the philosophers and the theologians. Surely the law can assert no competence to resolve the issue, particularly in view of the very nearly uniform high value which the law and mankind has placed on human life, rather than on its absence. . . . [W]hatever be the metaphysical or philosophical answer—speculative, perhaps

⁶ *Severns v. The Wilmington Medical Center*, Supreme Court of the State of Delaware, No. 39 (1980).

⁷ *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L. ed. 2d 147 (1973).

debatable, but hardly resolvable—and, however desirable it may be for society to otherwise treat . . . these problems with sensitivity, I am compelled to conclude that the matter is just not justiciable.⁸

The courts have manifestly and consistently adopted a “hands-off” policy with regard to the problem of boundaries between life and death, personhood and nonpersonhood in this form. But as Leonard Glantz (1983) documents, primarily through their linguistic juxtaposition of terms like “cognitive” and “sapient” versus “vegetative” and “lost human qualities,” the courts have *implicitly* utilized such personhood criteria in coming to some of their nontreatment decisions. In effect, they have latently ruled that the individual patients in question were close enough to being dead and nonpersons for the state to relinquish its interest in keeping them alive. In Glantz’s view, such decisions have been taken “in a way that does not seem to offend societal values.” He may be right. However, there is also the possibility that because of the indirect, segmentary, and subtle nature of these decisions, their full import for our “societal values” regarding personhood has not yet been recognized or understood.

Conclusion: A Search for Alternatives

Where, exactly, does this leave us? Faced with problems of personhood focused around biology and medicine that have become public issues, and that involve nothing less than our society’s beliefs and values concerning life and death, the individual and the community, and “our own and others’ identity and humanity” (De Craemer 1983), we are having difficulty in defining and dealing with them in ways that are acceptable to, and have authority over, us all. For reasons that are integrally connected with the nature of our social system and cultural tradition, none of the institutions that we have developed for resolving such “collective conscience” questions is perfectly suited to the task and, taken as a whole, they have common limitations and flaws. What this suggests is that we need to pay more attention to how our present arrangements might be modified to become more

⁸ *Becker v. Schwartz* No. 558 and *Park v. Chassin* No. 560, State of New York Court of Appeals, December 27, 1978.

effective instruments that would enable us to publicly resolve the essentially moral and religious dilemmas and conflicts that we are experiencing in a society undergoing profound change.

In the past, seekers after new arrangements have not only followed great philosophical and religious schools, but have found enlightenment in humanistic literary traditions. From Swift through Huxley and Orwell, imagination has been prodded with suggestions for more "effective instruments of resolution." In his journey to Erewhon, Samuel Butler observed a land where the ill and unfortunate were dispatched to lawyers, whereas thieves and murderers were ministered to by doctors:

This is what I gathered. That in that country if a man falls into ill health, or catches any disorder, or fails bodily in any way before he is seventy years old, he is tried before a jury of his countrymen, and if convicted is held up to public scorn and sentenced more or less severely as the case may be. . . . But if a man forges a cheque, or sets his house on fire, or robs with violence from the person, or does any other such things as are criminal in our own country, he is . . . taken to a hospital. . . . (Butler [1872] 1968, 111).

Certainly, medicine and law are likely to be central to any public resolution of our societal problem. Despite the frequent disputations and disjunctions, they are fields singularly committed—in their ethos and ethics, as well as in their reliance on case precedence as evidence—to the individual's rights and liberties. In their political interface with science and technology, however, traditional commitments are not sufficient.

Any modified arrangements for resolutions of dilemmas about personhood will also have to encompass more explicit considerations of the political economy of our society. The transcendent issues of our selves and our society require more open discussion of our collectivity along with our individuality. Our "rights" to self will have to be seen in relation to our "obligations" to others. Autonomy and equity are both highly valued but they are not easily reconcilable. The excessive emphasis on autonomy in our current deliberations has all but excluded our concern with equity. In an ideological climate in which the "econography" of cost-benefit analysis is gaining hold, the problems of personhood are in danger of being eclipsed.

Choosing alternatives to, or alterations of, our existing institutional

mechanisms—commissions, advisory boards, even our legislatures and courts—is not a simple matter for utopian social engineering. The effectiveness of any new consensus will depend on how skillfully and deeply it is able to address the individualism, the secularization and democratization, the problems of authority and community, the medicalization and technicalization, and the shift from private to public involvements that underlie the personhood issues now before us in our advanced, modern, pluralistic society. Such a consensus will not be easy to achieve. Perhaps that is just as well.

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