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# Consciousness: The Most Critical Moral (Constitutional) Standard For Human Personhood

Ronald E. Cranford, M.D.\*  
and David Randolph Smith, J.D.\*\*

For the past two decades, the medical profession and society have debated the definition of death. Some reasonable consensus has been reached on this issue, in theory and in practice. In the last few years, however, a far more important debate has been evolving — the definition of human personhood. Human personhood has been discussed extensively in the past with respect to the abortion question and other issues concerning the beginning of life. More recently, however, the definition of personhood has been raised with respect to termination of treatment decisions at the end of life and, in particular, on the appropriate care of patients in a persistent vegetative state.

Our major premise is that consciousness is the most critical moral, legal, and constitutional standard, not for human life itself, but for human personhood. There is nothing highly original in our approach to this particular issue; others have advanced similar arguments in recent years.<sup>1</sup> Our position is somewhat unique as it is derived more heavily from medical experience and medical reality. We feel that once society fully understands the medical reality of permanently unconscious patients and develops common sense views based on this understanding, certain legal and moral positions will follow logically. In our view, consciousness is the most important characteristic that distinguishes humans from other forms of animal life, going beyond the vegetative functions of heartbeat and respiration. Thus, we believe that the permanent loss of all con-

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\* Associate Physician in Neurology, Hennepin County Medical Center, Minneapolis, Minnesota.

\*\* Vanderbilt University School of Law, Nashville, Tennessee.

<sup>1</sup> See, e.g., Green & Wikler, *Brain Death and Personal Identity*, 9 PHIL. & PUB. AFF., 105, 105-06 (1980); R. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY, 46-51 (1976); Youngner & Bartlett, *Human Death and High Technology: The Failure of Whole Brain Formulation*, 99 ANNALS OF INTERNAL MED. 252-53 (1983).

sciousness is just as significant as the loss of all cardiopulmonary functions (the cardiopulmonary standard for death), and all brain functions (the neurological standard for death), in determining the moral and legal status of a human being.

Medicine has called this broad category of patients "permanently unconscious,"<sup>2</sup> but, at the present time, there is no consensus on any term from a moral or a legal standpoint. Neocortical death<sup>3</sup> is probably the best term thus far proposed for the permanent loss of all neocortical functions, in contrast to whole brain death, or brain death for the permanent loss of all brain functions. The moral or legal characteristics of this category, however, are not well delineated.

Regardless of one's views on human life, death and personhood, permanently unconscious patients are in an entirely separate category from all others. This classification is not new. Appellate courts in almost every major decision involving seriously impaired neurologic patients, often without explicitly stating so, have treated permanently unconscious patients in a separate category. Such patients are distinguishable from the dead, the terminally ill, and from patients with serious neurological impairments, for example those who are profoundly demented, but retain some degree of consciousness.<sup>4</sup> A series of recent decisions rendered by the New Jersey Supreme Court illustrated this view: *In re Jobs*,<sup>5</sup> *In re Peter*,<sup>6</sup> and *In re Conroy*.<sup>7</sup> In these cases, the court directly focused on the differences between patients with no consciousness<sup>8</sup> and those with only minimal consciousness.<sup>9</sup> Cessation of artificial nutrition and hydration, the court reasoned, could be justified even though the patients did not have a limited life expectancy because unlike the

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<sup>2</sup> Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27, 28 (1988).

<sup>3</sup> Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 851 n.6; see *infra* text at 237.

<sup>4</sup> *Barber v. Superior Ct.*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); see *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *Corbett v. D'Alessandro*, 498 So.2d 386 (Fla. Dist. Ct. App.), *rev denied*, 492 So.2d 1331 (Fla. 1986); *In re Prange*, No. 86-3398 (Ill. App. Ct. 1st Dist. 4th Div. Feb. 11, 1988); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass 417, 497 N.E.2d 626 (1986); *In re Gardner*, 534 A.2d 947 (Me. 1987); *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); *In re Jobs*, 108 N.J. 394, 529 A.2d 419 (1987); *Delio v. Westchester County Med. Center*, 129 A.D.2d 1, 516 N.Y.S.2d 363 (1987); *In re Eichner (In re Storar)*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981).

<sup>5</sup> *In re Jobs*, *supra* note 4.

<sup>6</sup> *In re Peter*, *supra* note 4.

<sup>7</sup> *In re Conroy*, 98 N.J. 321 (1985).

<sup>8</sup> *Jobs*, 108 N.J. at 402-03, 529 A.2d at 438.

<sup>9</sup> *Id.* at 406, 529 A.2d at 440.

patient in *Conroy*, they were permanently unconscious.<sup>10</sup>

The Child Abuse and Protection Amendments of 1984<sup>11</sup> draw the same distinction, distinguishing permanently unconscious infants from other categories of disabled newborns by using the unfortunate term "chronically and irreversibly comatose."<sup>12</sup> The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President's Commission) devoted a separate chapter to this clinical condition and made major social policy recommendations for this class of patients.<sup>13</sup> Major national medical organizations, such as the American Medical Association and the American Academy of Neurology, have also treated this category of patients separately when discussing the appropriateness of withdrawing treatment such as artificial nutrition and hydration.<sup>14</sup>

More recently, the Hastings Center project, "Guidelines for the Termination of Life-Sustaining Treatment and Care of the Dying,"<sup>15</sup> also placed these patients in a separate category. In discussing the reasonable person standard for termination of treatment decisions, the guidelines list three "important categories of patients," the patient who is terminally ill, the patient who has an illness or disabling condition that is severe and irreversible, and the patient with irreversible loss of consciousness.<sup>16</sup> Regarding the third category, the guidelines offer the following comments:

For the patient who has suffered an irreversible loss of consciousness, the major considerations in applying the "reasonable person" standard are somewhat different. Patients who are permanently unconscious are unaware of benefits or burdens. The only possible benefit to them of life-sustaining treatment is the possibility that the diagnosis of irreversible unconsciousness is wrong and they will regain consciousness. Accordingly, the major considera-

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<sup>10</sup> *Peter*, 108 N.J. at 375, 527 A.2d at 424.

<sup>11</sup> Child Abuse and Neglect Prevention and Treatment, 45 C.F.R. §§ 1340.1-20 (1987).

<sup>12</sup> *Id.* at § 1340.15(b)(2)(i).

<sup>13</sup> PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 197 (1983) [hereinafter PRESIDENT'S COMMISSION].

<sup>14</sup> *Withholding or Withdrawing Life-Sustaining Medical Treatment*, in CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION 12-13 (1986); see also *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, in NEUROLOGY (1988)(in press)(position approved by the Executive Board of the American Academy of Neurology on Apr. 21, 1988).

<sup>15</sup> Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 28-29 (1987).

<sup>16</sup> *Id.*

tions are whether a reasonable person in the patient's circumstance would find that this benefit, as well as the benefits to the patient's family and concerned friends (such as satisfaction in caring for the patient and the meaningfulness of the patient's continued survival) are outweighed by the burdens on those loved ones (such as financial cost or emotional suffering).<sup>17</sup>

In sum, permanently unconscious patients are in a medically, morally, and legally distinguishable class. The more important issue, however, is to discuss further the specific moral and legal characteristics of this new class of patients created by modern medical technology, and the implications of this discussion for other categories of patients. In these areas, we have far more questions than answers.

In this Article, we will first discuss the medical facts and goals of medicine that form the basis for the view that the capacity for consciousness is the most important moral and constitutional definition of human personhood, and that with permanent unconsciousness, personhood is lost. Second, we will discuss some major considerations arising from this premise.

## MEDICAL FACTS

Once certain medical facts are well understood and accepted by individuals and society, certain logically compelling moral and legal positions will follow. For example, in the brain death debate, once the medical profession had delineated specific medical criteria for brain death<sup>18</sup> and had determined that its diagnosis could be made with an extremely high degree of certainty, society became more willing to accept brain death as the moral and legal equivalent of the death of a person.<sup>19</sup>

Two of the most important barriers to acceptance of the permanently unconscious as a separate category, and to more fully developed views on the appropriate care and treatment of these patients, are not philosophical, legal, or social but are both medical. The first barrier is the reliability of the diagnosis of permanent unconsciousness: can it be made with an extremely high degree of certainty and

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<sup>17</sup> *Id.* at 29.

<sup>18</sup> *Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, A Definition of Irreversible Coma*, 205 J.A.M.A. 85 (1968).

<sup>19</sup> One of the most critical prerequisites to societal acceptance of brain death as the death of the person was assurance by the medical profession that the diagnosis and prognosis of this medical syndrome were extraordinarily accurate and that there were well-defined criteria which could be applied to individual cases. *Id.* at 85-86.

reliability, comparable to that of brain death? The second barrier is the concern that permanently unconscious patients may experience pain or suffering.

There is no satisfactory conceptual or philosophical definition of consciousness or awareness, and we will not attempt to give one at this time. It is possible, however, for neurological specialists to know when consciousness is absent and to determine with an extraordinarily high degree of certainty that there has been a permanent loss of consciousness.<sup>20</sup>

There are two important points to stress in the medical context. First, the anatomical substrate in the brain for consciousness is the cerebral cortex, more specifically the neocortex. It is a fundamental fact of neuroanatomy and neurophysiology that consciousness and the capacity to experience pain and suffering are functions of the neocortex. When a physician can determine on physical examination that there are no neocortical functions present, the patient is completely unconscious and has no capacity to experience pain or suffering. Second, permanent unconsciousness means a total loss of consciousness. Just as brain death means the loss of all brain functions, so permanent unconsciousness means the loss of all neocortical functions.

There are three major clinical types of permanently unconscious patients. The first, the prototype for this category, consists of those patients in a persistent vegetative state (PVS).<sup>21</sup> Patients in this condition have an eyes-open unconsciousness. They are awake, but unaware. The eyes are open at times, during periods of normal wakefulness, and they have physiologic sleep/wake cycles which are readily apparent to observers. The damage in these patients is to

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<sup>20</sup> "No one can ever have more than inferential evidence of consciousness in another person. A detailed analysis of the nature of consciousness is not needed, however, when considering the class of patients in whom all possible components of mental life are absent — all thought, feeling, sensation, desire, emotion, and awareness of self or environment. . . . "Most of what makes someone a distinctive individual is lost when the person is unconscious, especially if he or she will always remain so. Personality, memory, purposive action, social interaction, sentience, thought, and even emotional states are gone." PRESIDENT'S COMMISSION, *supra* note 13, at 174-75.

<sup>21</sup> For a discussion of PVS, see Brierly, Adams, Graham & Simpson, *Neocortical Death After Cardiac Arrest: A Clinical, Neurophysical, and Neuropathological Report of Two Cases*, 2 LANCET 560, 64 (1971); Cranford & Smith, *Some Critical Distinctions between Brain Death and the Persistent Vegetative State*, 6 ETHICS IN SCIENCE & MED. 199-209 (1979); Dougherty, Rawlinson, Levy & Plum, *Hypoxic-ischemic Brain Injury and the Vegetative State: Clinical and Neuropathologic Correlation*, 31 NEUROLOGY 991 (1981); Jennet & Plum, *Persistent Vegetative State After Brain Damage*, 1 LANCET 734-37 (1972); Levy, Carrona, Singer, Lapinski, Frydman & Plum, *Predicting Outcome From Hypoxic-ischemic Coma*, 253 J.A.M.A. 1420 (1985); Levy, Bates, Caronna, Cartledge, Knill-Jones, Lapinski, Singer, Shaw & Plum, *Prognosis in Nontraumatic Coma*, 94 ANNALS OF INTERNAL MED. 293-301 (1981); Levy, Knill-Jones & Plum, *The Vegetative State and Its Prognosis Following Nontraumatic Coma*, in BRAIN DEATH: INTERRELATED MEDICAL AND SOCIAL ISSUES 298-306 (1978).

the higher centers of the brain (the cerebral hemispheres), more specifically to the neocortex, while the lower centers of the brain, the brain stem, are relatively intact. The disparity between an intact brain stem and a severely damaged cerebral hemisphere gives rise to the disparity between wakefulness and consciousness. In other words, these patients are normally wakeful at times, but completely unconscious and unaware. If the brain stem were severely damaged as well, these patients would not have periods of wakefulness, and would be in a true coma. In PVS patients, because the brain stem is relatively unimpaired, these patients are not usually respirator dependent, and can live for years or decades. There are probably now in the United States 5,000-10,000 patients in a persistent vegetative state, and that number should significantly increase in future years with continued advances in cardiopulmonary resuscitation.

In contrast to the vegetative state, coma is an eyes-closed unconsciousness. In these patients, there is extensive damage to the brain stem. Because of this damage, these patients have impaired gag and cough reflexes and impaired respiration, which often result in medical complications leading to their deaths, usually within a matter of weeks or months. Thus, it can be said that patients in a true coma are "terminally ill;" with a high degree of probability, these patients will usually die within a period of weeks or months — rarely years. It is much easier emotionally for the family members to accept that the patient is unconscious when the eyes are closed.<sup>22</sup>

The third clinical category of permanently unconscious patients consists of anencephalic infants. Anencephaly is a severe congenital malformation in which the infant has essentially no cerebral hemispheres, but retains a variable amount of functioning brain stem. These children often will have periods of wakefulness with eyes open, and more appropriately can be described as having an eyes-open unconsciousness. Unlike those in persistent vegetative state, however, these infants do not have normal brain stems and usually succumb to medical complications within a matter of days or weeks.

Space does not permit us to develop fully the major similarities and differences between the persistent vegetative state and anencephaly, the two major categories of eyes-open unconsciousness. A complete understanding of these medical similarities and differences is critical to the current controversy concerning removal of organs from anencephalic infants. If it were permissible to remove organs from anencephalics, would it be equally permissible to allow for the retrieval of organs from vegetative state patients, as

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<sup>22</sup> Cranford, *Termination of Treatment in the Persistent Vegetative State*, 4 SEMINARS IN NEUROLOGY 36-44 (1984).

both are in a state of eyes-open unconsciousness? In an anencephalic infant, neurologic damage is directly and easily observable to health care professionals and to parents at birth. This is because there are essentially no cerebral hemispheres and little skull present. This readily observable lack of hemisphere and skull permits the diagnosis of anencephaly to be established before birth, by ultrasound, and immediately after birth with the same degree of certainty as brain death. In the vegetative state, the severe damage to the neocortex is not directly observable, and currently the diagnosis and prognosis cannot be established with the same degree of certainty or as quickly as that of either anencephaly or brain death.<sup>23</sup>

Another category closely related to these three is the pre-conscious fetus. These human beings have many of the characteristics of the permanently unconscious patient — lack of awareness and lack of the capacity to experience pain and suffering — but have the potential for developing normal consciousness. We believe there are more similarities relating to consciousness between the end of life and the beginning of life than previously appreciated. If this is the case, the arguments concerning when human personhood ends will have significant impact on when human personhood begins during gestation. One important potential legal implication of this view could be that the most critical constitutional threshold during pregnancy for recognizing fetal rights over maternal rights is the point at which the fetus develops consciousness, albeit minimal, and the capacity to experience pain and suffering, rather than at the point of viability or birth. *Roe v. Wade*<sup>24</sup> should have focused more on consciousness, not viability, as the more crucial threshold for the balance between maternal and fetal rights.<sup>25</sup>

From a medical view, the permanently unconscious patient, whether vegetative, comatose, or anencephalic, is not able to experience any thoughts or feelings, pleasure, pain, or suffering. According to the official position of the American Academy of Neurology on persistent vegetative state patients, for example,

Persistent vegetative state patients do not have the capacity to experience pain or suffering. Pain and suffering

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<sup>23</sup> Caplan, *Should Fetuses or Infants Be Utilized as Organ Donors?* 1 *BIOETHICS* 119-40 (1987); Cranford & Roberts, *Use of Anencephalic Infants as Organ Donors: Crossing a Threshold*, in *PEDIATRIC BRAIN DEATH* 150 (H. Kaufman ed. 1987); Fletcher, Robertson & Harrison, *Primates and Anencephalics as Sources for Pediatric Organ Transplants: Medical, Legal and Ethical Issues*, 1 *FETAL THERAPY* 150-64 (1986).

<sup>24</sup> 410 U.S. 113 (1973).

<sup>25</sup> Glantz, *Abortion and the Supreme Court: Why Legislative Motive Matters*, 76 *AM. J. OF PUB. HEALTH* 1452 (1986); *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986).

are attributes of consciousness requiring cerebral cortical functioning, and patients who are permanently and completely unconscious cannot experience these symptoms. There are several independent bases for the neurological conclusion that PVS patients do not experience pain or suffering. First, direct clinical experience with these patients demonstrates that there is no behavioral indication of any awareness of pain or suffering. Second, in all PVS patients studied to date, post-mortem examination reveals overwhelming bilateral damage to the cerebral hemispheres to a degree incompatible with consciousness or the capacity to experience pain or suffering. Third, recent data utilizing positron emission tomography (PET) indicates that the metabolic rate for glucose in the cerebral cortex is greatly reduced in PVS patients, to a degree incompatible with consciousness.<sup>26</sup>

As we stated earlier, one important key to the acceptance of the permanently unconscious as a distinguishable category of patients is the degree of certainty of the diagnosis and prognosis. Until recently, the diagnosis of the vegetative state was entirely clinical; there were no useful confirmatory laboratory studies available.<sup>27</sup> This now has changed somewhat with the increasing use of CAT (computerized axial tomography) and MRI (magnetic resonance imaging) scans. These radiologic studies show massive structural damage to the cerebral hemispheres in the PVS patient and can help to confirm the clinical findings.

The most promising laboratory procedure for confirming the diagnosis of the vegetative state may be PET scanning.<sup>28</sup> This procedure quantitatively measures blood flow and metabolism of oxygen and glucose at the neocortical level. PET studies may be extremely useful to confirm the diagnosis of the persistent vegetative state, and establish the diagnosis with a high degree of certainty within days, weeks, or months after the initial injury. While these studies cannot determine whether PVS is irreversible, they can determine the level of metabolism of the neocortex. Studies have shown unequivocally that the metabolic rates of the neocortex in patients in a persistent vegetative state are 50-60% below the level of patients with a normal level of consciousness, including patients

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<sup>26</sup> *Supra* note 14, at 1-2.

<sup>27</sup> Clinical diagnoses are obtained by observation of the patient and by physical examination without laboratory studies.

<sup>28</sup> Levy, *Differences in Cerebral Blood Flow and Glucose Utilization in Vegetative Versus Locked-in Patients*, 22 ANNALS OF NEUROLOGY 673-82 (1987)[hereinafter *Cerebral Blood Flow*].

with locked-in syndrome (those who are severely paralyzed but who have normal mentation).<sup>29</sup> The markedly decreased metabolic levels are comparable to levels obtained in deep anesthesia or deep coma.<sup>30</sup>

These views on the medical reality of the PVS patient are scientific medical positions — statements of fact, not values. Whatever one's opinions on quality of life, euthanasia, autonomy, privacy, ensoulment, abortion, or other deeply held opinions on the meaning of life, whatever one's judicial or constitutional philosophy: judicial activism, judicial restraint, legal positivism, legal realism, or original intent, the medical reality remains the same.

## GOALS OF MEDICINE

What are some of the persuasive arguments relating the medical characteristics of the permanently unconscious patients to their moral and legal status? These arguments have most extensively developed in connection with the persistent vegetative state, but they will apply generally to all categories of permanently unconscious patients. Once it can be determined that a human being is permanently unconscious, the traditional goals of medicine can no longer be served.

Medicine cannot promote autonomy or self-determination because autonomy, self-determination, and the constitutional right to privacy are simply meaningless for a patient in this condition. Important social goals may be served, however, by showing respect and care for the body of a patient who is permanently unconscious, as well as respect for the previously stated wishes of the patient. But the patient cannot in any way experience, enjoy, or effectuate the rights or benefits of autonomy or privacy.

Medicine cannot promote the best interests of these patients because these patients have no interests in further treatment or discontinuation of treatment, or in continued existence at all.

Medicine cannot promote the beneficence of the benefit/burden calculus because, again, the patient cannot experience either benefits or burdens of treatment, non-treatment, or of continued existence. Continued existence and treatment or non-treatment may be of enormous importance to the patient's loved ones and to society, but not to the patient.<sup>31</sup>

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<sup>29</sup> Mentation is another term for consciousness.

<sup>30</sup> *Cerebral Blood Flow*, *supra* note 28, at 673-74, 679.

<sup>31</sup> *Supra* note 4, at 425 ("While a benefits/burdens analysis is difficult with marginally cognitive patients like Claire Conroy, it is essentially impossible with patients in a persistent vegetative state. By definition, such patients, like Ms. Peter, do not experience any of the

Medicine cannot preserve and maintain health because there is no health for a patient in a persistent vegetative state, only life in terms of the most primitive vegetative functions. *Brophy v. New England Sinai Hospital, Inc.*<sup>32</sup> was the first major case to address directly the issue of withdrawal of a feeding tube from a patient in a vegetative state. In that case, some physicians caring for Brophy at New England Sinai Hospital, as well as a lawyer appointed by the court to represent Brophy's "best interest," repeatedly pointed out that Brophy was "perfectly healthy," and they seemed to take a great deal of professional pride in the fact that he was not dying and could live for many years in this condition, presumably indicating how "healthy" he was. Indeed, whether preservation of life can be an independent moral and legal value is seriously called into question when a patient is permanently unconscious and has only vegetative functioning. A patient in a persistent vegetative state has no health; health is an empty concept for a patient without consciousness.

Medicine cannot minimize or relieve pain and suffering because these patients cannot experience pain and suffering. Medicine cannot minimize disability because disability is maximal. Permanently unconscious patients are not weak, disabled, disadvantaged, handicapped, or helpless any more than someone who is dead.<sup>33</sup>

Thus, the essential arguments for determining whether treatment should be continued or discontinued in the permanently unconscious patient become the same as those used to decide on the appropriate treatment of a person who is dead. In this respect, permanently unconscious patients are more like the dead than the living.

#### MORAL, LEGAL, AND CONSTITUTIONAL CONSIDERATIONS

If one accepts the fundamental medical view that permanent unconsciousness can be diagnosed with a high degree of certainty, that permanently unconscious patients do not have the capacity to

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benefits or burdens that the *Conroy* balancing tests are intended or able to appraise. Therefore, we hold that these tests should not be applied to patients in the persistent vegetative state.").

<sup>32</sup> 398 Mass. 417, 497 N.E.2d 626 (1986).

<sup>33</sup> *Supra* note 13, at 181-82 ("The primary basis for medical treatment of patients is the prospect that each individual's interests [specifically, the interest in well-being] will be promoted. Thus, treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible.")

experience thoughts or feelings, pain or suffering, and that the goals of medicine can no longer be achieved in the class of patients, then certain major considerations appropriate to the care of these patients and to their moral and legal status need to be recognized and addressed.

Since permanently unconscious patients do not have any interests except for preservation of the body, questionably an interest in light of the permanent loss of consciousness, there should be only a weak presumption toward medical treatment and preservation of life, one which is easily overcome by relevant considerations for non-treatment.

In living patients, even the terminally ill, or those patients with illnesses or disabling conditions that are severe and irreversible, there is still a strong presumption towards life. Autonomy and beneficence are the guiding principles, and the burden is on those who want to show why treatment should be stopped. On the other hand, once death has been diagnosed in accordance with accepted medical criteria, the pronouncement of death and the discontinuation of life-support systems are mandatory. Autonomy, beneficence, the previous wishes of the patient, and the wishes of the family are not relevant considerations except from a humanitarian standpoint. Further, numerous legal mechanisms are triggered automatically at the time of death.

Where are permanently unconscious patients on this continuum? As we have discussed, autonomy and beneficence are of little or no relevance. The state's interest in preserving life is less compelling when a patient retains only the vegetative functions of basic biologic existence and is irreversibly incapable of experiencing anything.

It seems then that permanently unconscious patients have characteristics of both the living and the dead. It would be tempting to call them dead and then retrospectively apply the principles of death, as society has done with brain death, but this approach encounters major problems. One of its most basic difficulties is that, despite considerable advances in experience and diagnostic technology, the medical profession thus far has been unable to achieve the same degree of certainty of diagnosis and prognosis in this class of patients (except for anencephaly), as with the cardiorespiratory or neurological standard of death. Although there is no more benefit from continued treatment or continued existence for these permanently unconscious patients than there is for patients who are dead in the traditional sense, redefining death to include permanently unconscious patients requires a fundamental and radical reappraisal of

the traditional notion of death. The traditional and well-accepted standards of death have been based on the loss of both consciousness (functions of the cerebral hemispheres) and the integrative capacity of the brain (functions of the brain stem). The critical question is whether permanently unconscious patients retain personhood and whether there should be a weak presumption towards treatment, or towards non-treatment.

The changing legal status of the permanently unconscious will have profound implications for both the civil and criminal law.<sup>34</sup> For instance, what should be the legitimate and appropriate charges against an assailant who allegedly injures a person and causes the patient to go into a vegetative state? Currently the laws on homicide only apply when the victim is dead. Many would argue, as we would, that the persistent vegetative state is worse, for the patient's loved ones and society, than death. The legal sanctions relating to homicide should therefore be equivalent to or heavier than those for causing the death of a person. Not only should society consider increasing the criminal and civil sanctions for causing a person to become permanently unconscious, but society may also wish to reduce the criminal sanctions if a defendant causes the death of someone already in a persistent vegetative state.

Why is the persistent vegetative state worse than death? While the level of consciousness is the same for both, there is far greater anguish and despair in caring for a hopelessly ill patient whose eyes are open and who appears to be consciously interacting with the environment. This situation takes a tremendous toll on a patient's family, both emotionally and economically. A great deal of false hope can be generated by the fact that the patient's eyes are open. It takes a great deal of time for family members to come to the intellectual and emotional acceptance that the patient is not conscious nor experiencing pain or suffering. It is generally easier for a family to accept the hopelessness of the situation when a patient is in a coma and has no sleep/wake cycles. The guilt, anguish, and ambivalence that face the families of patients in the vegetative state are substantial.

Because of advanced medical technology, the medical profession now has the ability to manipulate the time and fact of death and the dying process for a variety of reasons, both good and bad, and in a variety of medical situations. This applies to brain death, and even more so to the persistent vegetative state and to many other medical conditions in which the patient is dependent on life-support systems for continued survival. In malpractice actions, permanently uncon-

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<sup>34</sup> See Smith, *supra* note 3.

scious patients produce more substantial awards than dead patients, especially when they are seriously disabled newborns. Brain damage cases typically result in million or multi-million dollar jury awards, none of which, of course, will benefit in any way the permanently unconscious patient. In civil suits, the patient can be kept alive, though permanently unconscious, to benefit the survivors. When suits are settled successfully in favor of the family, they may then decide to discontinue treatment when it is to their financial advantage. The continued existence or death of the patient may substantially affect the course of litigation; the Sunny von Bulow case is a prime example.<sup>35</sup> The ability to manipulate the time and fact of death in these patients is significant, and the potential for abuse is enormous.

Some have recently advocated keeping permanently unconscious patients alive for tax purposes and then timing the pulling of the plug to maximize insurance disability payments or pensions.<sup>36</sup> Others have advocated living will directives which would minimize adverse outcomes on estate taxes.<sup>37</sup> Insurance companies may have powerful motivations for wanting treatment stopped, while in some cases of large disability coverage, relatives may be motivated to keep a patient alive indefinitely on artificial life-support systems, especially when the treatment involves only artificial feeding and basic nursing care in a vegetative state patient. Currently the courts seem to have sanctioned a "deregulation" approach, leaving these decisions to the relatives and families absent disagreement among the family or with physicians. This approach ignores the potential conflict of interest that family members might have in bringing about death to effectuate inheritance, insurance proceedings, remarriage without a divorce or other ulterior benefits.

With respect to organ retrieval from and medical experimentation on permanently unconscious patients, there is great potential for good as well as harm to both individuals and society. The current controversy over the appropriateness of removing vital organs from anencephalic infants highlights this dilemma. Anencephalic infants are never conscious, and they are terminally ill. But removal of the vital organs of heart, lungs, liver, or both kidneys, however, would be the direct proximate cause of death and is currently medically, morally and legally unprecedented. The removal of vital or-

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<sup>35</sup> Smith, *supra* note 3 at 872 n.128 (because Sunny Von Bulow was reduced to a persistent vegetative state, her husband Claus could only be charged with attempted murder and not first degree murder).

<sup>36</sup> Smith, *supra* note 3, at 887.

<sup>37</sup> *Id.*, at 872-73 n.130 (citing Jorrie & Standley, *The Tax Advantages of Lingering Death*, 48 TEX. B.J. 1070 (1985)).

gans from a living human person (as person is currently defined by the law) is considered homicide and contrary to traditional norms of medicine. If an anencephalic infant is never conscious and, therefore, could be considered a non-person, should it be homicide to take its vital organs? Should homicide laws refer only to persons, rather than all live human beings? An anencephalic infant or a persistent vegetative state patient cannot be harmed by either continued treatment or discontinuation of treatment. Therefore, how can an anencephalic infant or any permanently unconscious patient, who cannot be morally harmed, be the victim of a homicide?

A further important consideration is the wise and just use of society's limited resources. Once the diagnosis of permanent unconsciousness has been established beyond any reasonable doubt, it becomes increasingly difficult to justify financial or other burdens on families, health care providers, and society. The general impact on the time, effort, morale, and finances of health care providers, family, and friends can be enormous. Society would be far better served if these resources were focused on preserving health and rehabilitating persons who could experience benefit from medical care.

Once the medical reality of the utter hopelessness of this condition, coupled with the potential for prolonged survival, becomes more widely recognized, society will begin to question existing standards of care, especially admission of permanently unconscious patients to acute care institutions or to intensive care units. Third-party payers will find it increasingly difficult to justify reimbursement for the care of these patients, especially in an acute care setting. The estimated annual cost of maintaining persistent vegetative state patients in the United States is \$120 million to \$1.2 billion.<sup>38</sup> Why should society spend this much money for patients who can never benefit from continued treatment in any way, when 37 million people with no medical insurance or coverage have such a reduced opportunity for even a minimal level of health care? Is this social justice?

The medical reality of the vegetative state raises substantial legal and constitutional questions in the interpretation and application of the Bill of Rights and the fourteenth amendment. Do any constitutional rights exist for a patient who is permanently incapable of experiencing or exercising these rights in any way? As Professor Tribe notes, "[t]he Constitution was consecrated to the blessings of liberty for ourselves and our posterity — yet it contains no discussion of the right to be a *human* being; [it contains] no definition of a

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<sup>38</sup> Cranford, *supra* note 2, at 30-32.

person. . . ."<sup>39</sup> John Stuart Mill noted that the government cannot do anything against the will of an individual, unless it is to protect others.<sup>40</sup> Liberty and personhood encompass an inner-directed and an outer-directed will. An individual who is permanently unconscious has no will. In the absence of will, thought, expression, or consciousness, legal rights and liberties have no reference and thus no meaning. It is a case of existential checkmate.

Can any of the rights enumerated in the Bill of Rights or in the fourteenth amendment to the Constitution be experienced, effectuated, or exercised by a person who is permanently unconscious? The answer is clearly and unequivocally no.

All rights enumerated in the Constitution and the Bill of Rights are predicated on consciousness, or the capacity for consciousness, except for the right to life itself, which becomes meaningless when consciousness can never exist, as in an anencephalic infant, or when consciousness is forever extinguished, as in a vegetative state patient.<sup>41</sup> The Constitution does not define the word person or human being; this has been left to the courts to work out as best they can. The best example of this is how some state courts have defined "person" to include the fetus or unborn child for the purposes of state criminal laws (particularly vehicular homicide and feticide laws),<sup>42</sup> torts (wrongful death statutes)<sup>43</sup> and property (inheritance laws).<sup>44</sup> Indeed, the determination of what constitutes a person under the fourteenth amendment is a question of law to be determined by the federal courts, in the absence of a constitutional amendment.<sup>45</sup>

## CONCLUSIONS

Permanently unconscious patients are creatures of modern day medicine. Society must begin to grapple with the substantial implications of this unique class of individuals. Before there can be any consensus on the most appropriate way to deal with the permanently unconscious, society must be convinced that the diagnosis and prognosis of the condition are certain, that these patients experience no pain and suffering, and that the traditional goals of

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<sup>39</sup> L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1308 (1988) (emphasis in original).

<sup>40</sup> J. MILL, *ON LIBERTY* 157 (1859).

<sup>41</sup> Cranford, *Life, Death, Awareness, and Suffering* in *SOCIAL RESPONSIBILITY: BUSINESS, JOURNALISM, LAW AND MEDICINE* 41-50 (L. Hodges, ed. 1985).

<sup>42</sup> See, e.g., MASS. GEN. L. ch. 90, § 24G (1969 & Supp. 1988); FLA. STAT. § 782.09 (1976).

<sup>43</sup> See, e.g., ILL. ANN. STAT. ch. 70, para. 2 (1959); 42 PA. CONS. STAT. § 8301(a) (1982).

<sup>44</sup> See, e.g., IDAHO CODE § 32-102 (1983); ILL. STAT. ANN. ch. 110, para. 13-118 (Smith-Hurd 1983).

<sup>45</sup> *Doe v. Israel*, 358 F. Supp. 1193 (D.R.I. 1973).

medicine cannot be served once a diagnosis of permanent unconsciousness has been made. Once society is convinced of all this, significant moral and legal questions arise, some of which have been addressed in this Article. While, in our view, permanently unconscious patients lack personhood, we feel there should be a vigorous dialogue and debate about the actual medical reality, and the moral, legal characteristics of these patients, before any definitive labels are attached to them as a category.