Title: Looking for Signs of Life: A Christian Perspective on Defining and Determining Death

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Abstract (183/200): Looking to Scripture through the eyes of contemporary medical experience, I analyze the meaning of the criteria used for determining death, specifically in the light of Jesus' final moments and the resurrection of the Shunammite's son in 2 Kings, chapter 4. I argue that four theses are consistent with, and informed by, these passages that can help guide Christian belief and decision-making about how death is determined in the clinical context: (1) death is neither permanent nor irreversible; (2) something like the "brain dead" state is, at best, a confounding state that requires one to "pace and pray" or let go; (3) that the case for determining death by neurologic criteria depends on the "working togetherness" of the body's parts for the sake of impacting its environment; and (4) that the practice of neurologically-based death determination is a response to the problem of disaggregation of the human form into its organ systems that modern critical care medicine makes possible. I end with advice about how Christians might approach the debates over the law and practice even if they cannot come to a consensus.

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How should Christians think about defining and determining death? Answering this question is daunting for two reasons. First, choices must be made on a host of complex issues that inevitably put one in disagreement, sometimes sharply, with other Christians. Second, the reasons behind those choices may not, and perhaps need not, be distinctly Christian in their character or origin, and are therefore hard to settle within the framework of Christian theology. For example, it would seem that determining when someone is dead is a medical matter, and so the theologian should defer to physicians to settle the question. Pope Pius XII recommended as much in 1957 and this deference still has a certain appeal even after the upheavals of the 1960s (Pius XII 2002).[1] One of those upheavals was that "brain death" was ushered into respected medical parlance by the Harvard Ad Hoc Committee in 1968 (Ad Hoc Committee of the Harvard Medical School 1968). Nevertheless, something of a consensus took hold that neurologic criteria for determining death were acceptable within Christian theology, because they were thought to be consistent with the view that death is the separation of the soul from the body (Veith et al. 1977; Campbell 2022). But since the early 2000s that consensus has eroded with doubt even extending to how death is determined by accepted practice on circulatory and respiratory criteria as well (Shewmon 2001; Nguyen 2018). Christians may agree that their mortal bodies "cannot inherit the kingdom of God" (1 Corinthians 15:50), but they are increasingly uncertain about how their physicians *know* when someone is dead.

[1] According to the Pope, "It remains for the doctor, and especially the anesthesiologist, 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, "Where the verification of the fact in particular cases in concerned, the answer cannot be deduced from any religious and moral principle and, under this aspect, does not fall within the competence of the Church" (Pius XII 2002, p. 312, 315.).

Catholic thinkers have dominated the theological and biophilosophical discussion on neurologic criteria for death in recent years (Shewmon 2001; Sorondo 2007; Shewmon 2011; Eberl 2011; Accad 2015; Moschella 2016; Condic 2016; Lee 2016; Austriaco 2016b). While I appreciate how they frame the discussion, I seek to articulate a framework for approaching the discussion in general, and to advance the case for "brain death" in particular, from a Protestant perspective. Looking to Scripture through the eyes of contemporary medical experience, I analyze the meaning of the criteria used for determining death, specifically in the light of Jesus' final moments on the cross and the resurrection of the Shunammite's son in 2 Kings, chapter 4. I argue that four theses are consistent with, and informed by, these passages that can help guide Christian belief and decision-making about how death is determined in the clinical context: (1) death is neither permanent nor irreversible in an absolute sense; (2) something like the "brain dead" state is, at best, a confounding state that requires one to "pace and pray" or let go; (3) that the case for determining death by neurologic criteria depends on the "working togetherness" of the body's parts for the sake of impacting its environment; and (4) that the practice of neurologically-based death determination is a response to the problem of disaggregation of the human form into its organ systems that modern critical care medicine makes possible. I end with advice about how Christians might approach the debates over the law and practice even if they cannot come to a consensus.

Can Scripture shed any light?

Can Scripture shed any light, however dim, on what the signs of life and death might be? To answer 'yes' risks foolhardiness, and for a long time I dismissed the possibility that it could be of any help. Yet I have been intrigued by three passages. The

first two, which invite rather than settle questions, are from Mark 15:37–38 and Matthew 27:50-51. In Mark, it is said that "With a loud cry, Jesus breathed his last" and "The curtain of the temple was torn in two from top to bottom."[2] Likewise, Matthew 27:50-51 says, "And when Jesus had cried out again in a loud voice, he gave up his spirit. At that moment the curtain of the temple was torn in two from top to bottom." It is striking that the text highlights the loss of his breath combined with his loss of his consciousness, which helped drive out that last breath in the form of a cry, as signifying Jesus' death (giving up his spirit).

Moreover, these events occasion a miracle that achieved certain goals of the atonement, specifically, obtaining access to a "more perfect tabernacle" in which there is "eternal redemption" and where penitents can "cleanse" their "consciences from acts that lead to death"—none of which, according to the author of Hebrews, could be achieved without Jesus' death (Hebrews 9:11-15). While it is probably true that his heart stopped too, one wonders if we could get it going again if only for a short time assuming we could time-travel and deploy our amazing resuscitative techniques and technologies. In any event, since whatever is true of Christ's human life is true of ours, we ought to pay attention to the, at least hinted, criteria upon which the Father determined the Son's human life to be over, that is, the combined loss of consciousness and breathing.

Another question to settle: Is there any Scriptural reason to discount the significance of the heartbeat? The hint towards the significance of consciousness and breathing highlighted in the Gospels leads me to focus at length on a second passage,

[2] All passages are quoted from the New International Version (2011).

specifically the story of Elisha and the Shunammite's son in 2 Kings, chapter 4, which is worth quoting at length (select verses are 16-22, 27-29, 31-36):

> 16"About this time next year," Elisha said [to the Shunammite woman, who was childless], "you will hold a son in your arms." "No, my lord!" she objected. "Please, man of God, don't mislead your servant!" 17 But the woman became pregnant, and the next year about that same time she gave birth to a son, just as Elisha had told her.
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> 18 The child grew, and one day he went out to his father, who was with the reapers. 19 He said to his father, "My head! My head!" His father told a servant, "Carry him to his mother." 20 After the servant had lifted him up and carried him to his mother, the boy sat on her lap until noon, and then he died.21 She went up and laid him on the bed of the man of God, then shut the door and went out.22 She called her husband and said, "Please send me one of the servants and a donkey so I can go to the man of God quickly and return." [...]
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> 27 When she reached the man of God at the mountain, she took hold of his feet. Gehazi came over to push her away, but the man of God said, "Leave her alone! She is in bitter distress, but the LORD has hidden it from me and has not told me why." 28 "Did I ask you for a son, my lord?" she said. "Didn't I tell you, 'Don't raise my hopes'?"
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> 29 Elisha said to Gehazi, "Tuck your cloak into your belt, take my staff in your hand and run. Don't greet anyone you meet, and if anyone greets you, do not answer. Lay my staff on the boy's face." [...] So he got up and followed her. 31 Gehazi went on ahead and laid the staff on the boy's face, but there was no sound or response. So Gehazi went back to meet Elisha and told him, "The boy has not awakened."
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> 32 When Elisha reached the house, there was the boy lying dead on his couch.33 He went in, shut the door on the two of them and prayed to the LORD.34 Then he got on the bed and lay on the boy, mouth to mouth, eyes to eyes, hands to hands. As he stretched himself out on him, the boy's body grew warm.35 Elisha turned away and walked back and forth in the room and then got on the bed and stretched out on him once more. The boy sneezed seven times and opened his eyes.
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> 36 Elisha summoned Gehazi and said, "Call the Shunammite." And he did. When she came, he said, "Take your son." 37 She came in, fell at his feet and bowed to the ground. Then she took her son and went out.

How should we understand this text? Bible scholars might draw a parallel to Israel's origin story, which depended on a similar miracle that brought "a child of the promise" into the world from Abraham and Sarah (Rosenberg 2020). Or they might connect the

story to Elijha who also “stretched himself out” on a dead boy “three times” and cried out to God to bring him back to life (1 Kings 17:21). Or they might allude to themes like the return from exile, as Bible scholars tend to do (Hess 2023). But I am no Bible scholar. Rather, I am a philosopher of medicine who, like others before me, will probably torture the text for details it was never written to address—namely, the relevant criteria used to determine death and what to do when they manifest. Nonetheless, there are some clues here that support a framework that can help Christians (1) think more generally about defining and determining death in our technological and litigious age, and (2) guide their choices on matters of policy and practice.

Neither permanent nor irreversible

The first thing to say, at least from a theological point of view, is that death itself—the process or event—is neither permanent nor irreversible. In the contemporary biomedical context this is a shocking thing to say which invites incredulous stares. The best one could hope for in a clinical setting is something like: “The family believes, for religious reasons, that death is reversible; therefore, they should be approached in a culturally competent way in consultation with Spiritual Care.” Otherwise, the idea of “reversible death” is thought to be absurd, on the same level as a square circle.

There is a good reason for this, of course. From a clinical perspective, if you are able to resuscitate a patient after cardiac arrest, it is hard to believe that the patient died and then came back to life. The ordinary means of CPR should not produce such extraordinary results. Rather, the best explanation is that the patient was alive the whole time, but alarmingly, was not showing observable signs of life. This commonsense

thought has led more secular interpreters of the text to treat Elisha's story as providing an ancient example of mouth-to-mouth resuscitation on someone who was merely in a comatose state (Trubuhovich 2005; Bar 2011). To their minds, this just has to be the case. No one "survives" death. You die and that is it. The Christian view, grounded in the resurrection of Jesus no less, is simply not credible. A Christian theology of death, however, is consistent with a key norm of our death determination practices, that is, every declaration of death made by a human observer should be true and final in the sense that it would take a miracle to falsify.

Thus, contemporary death determination practice requires some sort of "irreversibility" condition on the language of death declarations. Hence the model statute in the United States reads:

> An individual who has sustained (1) either *irreversible* cessation of circulatory and respiratory functions or (2) *irreversible* cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards (President's Commission 1981, p. 2, emphasis added).

One might reasonably suppose that one should declare death only if the signs of death "cannot be reversed." Clinicians are then duty bound to use tests that show "irreversibility" has been met. Yet this position has fallen on hard times, because nature does not easily reveal this condition to us. To precisely uncover it would require the trial of every known resuscitative measure we have on a host of moribund patients before a declaration could be made. It is hard to imagine carrying out such a ghoulish experiment on a dying person. Even if it were performed with the consent of the patient, the results would become dated as resuscitative technology would likely improve shortly thereafter. Medical practice, therefore, has decided that an intention to wait some number of minutes (usually five), without any attempts to resuscitate the patient is

necessary for a reliable determination of death at least on circulatory-respiratory grounds. Indeed, this operational interpretation of "irreversibility" was documented by the Medical Consultants on the Diagnosis of Death to the 1981 President's Commission:

> *Irreversibility* is recognized by the persistent cessation of functions during an appropriate period of observation and/or trial of therapy. In clinical situations where death is expected, where the course has been gradual, and where irregular agonal respiration or heartbeat finally ceases, the period of observation following the cessation may be only the few minutes required to complete the examination. Similarly, if resuscitation is not undertaken and ventricular fibrillation and standstill develop in a monitored patient, the required period of observation thereafter may be as short as a few minutes (President's Commission 1981, 162).

This interpretation, however, has the consequence of making this kind of determination of death more of a matter of intention and less a matter of discovery. That is to say, we must account for what we are willing to do or not in order to determine death.

To make matters harder, the interests of organ transplantation strongly motivate the search for a precise moment of death so as to permit rapid retrieval and graft survival. Thus, contemporary bioethics recommends the substitution of the weaker condition of "permanence" in place of "irreversibility" to require knowing when the clinical signs of death "will not" be reversed instead of knowing when they "cannot" be reversed (Bernat 2010). The best reason for this change is that it reflects how "irreversibility" is interpreted in accepted medical practice anyway—regardless of organ donation. What this means, however, is that death declarations can be consistent with knowing one *could* resuscitate the patient, which opens the door to all sorts of mischief that only needs to be labeled "acceptable medical practice" in order to pass muster. The debate over normothermic regional perfusion in donation after circulatory determination of death protocols — which involves restarting oxygenated circulation in the body, occluding vessels to the brain so as to "maintain" the permanent absence of

brain circulation, and perfusing organs for transplant, perhaps even recovering the heartbeat—is a case in point (Manara et al. 2020). Some within transplant medicine would like the rest of the medical field and the general public to accept that, not only is an unwillingness to resuscitate the patient part of the determination of death, but that acting on the body with the intention to prevent vital brain functions is part of it too (Parent et al. 2020).[3] While a significant portion of the medical field is hesitant to make this change (American College of Physicians 2021), transplant organizations are increasingly in favor of it (Croome et al. 2023).

Like other members of the public, Christians are deeply concerned over these language games and take sides. Some think that death should not be declared until it is known that the patient is beyond the possibility of resuscitation, requiring documentation that "respiration has ceased, the heartbeat has stopped, and the body is grey and cold followed by other overt signs indicative of a corpse" (Nguyen 2018, p. 3). Others go so far to say death can be declared only when signs of putrefaction set in (Oderberg 2019). Still others, wanting to save the permissibility of organ donation from at least those determined dead on circulatory-respiratory criteria, would permit a death declaration on the basis that one "passes away" when the heart stops and no effort is made to restart it (Shewmon 2010). Many others accept the so-called "whole brain" formulation codified in US law while others accept a "partial brain" view like the United

[3] According to Parent et al.: "Ultimately, the circulatory death determination is valid because permanence leads to irreversible and complete cessation of brain function. Once death has been declared by circulatory cessation, neuronal degradation begins. If this process continues unimpeded, legal and cellular death by permanent cessation of brain function will eventually occur. Spontaneous and evoked electrical activity ceases when cerebral blood flow falls below 16-18 mL/100 g/min. Accordingly, vessel ligation can prevent perfusion of the brain when NRP starts and can ensure continued natural neuronal hypoxemia and ischemic progression to complete loss of brain function." Whatever is to be said about this practice, it clearly and directly involves the transplant team in the determination the death, which creates an unacceptable conflict of interest.

Kingdom's that focuses on brainstem failure (Sulmasy 2019; Omelianchuk 2021). Some even go so far to say that only the loss of consciousness matters (Wennberg 1989).

What the Old Testament passage teaches, however, is familiar: God is the giver of life and it can be taken away or given back according to God's good purposes. Whatever difficulties there are in scientifically determining death, it is something everyone at some point can recognize whether a head injury is the cause or not. Death has a finality to it, but it does not get the last word over our story. The promise of eternal life changes how we are to view our earthly life, and it empowers us to follow Jesus in saying "Father, into your hands I commit my spirit" when our earthly lives come to an end. The promise of eternal life also empowers us to adopt the attitude of St. Paul who wrote: "To live is Christ, but to die is gain" (Philippians 1:21) and to view our earthly life as directed to the service of God and others (Philippians 1:22-26). This permits us to not prolong the transition from earthly to eternal life when we are no longer capable of such service (Butler 2019, 39).

A confounding state

The second thing to notice about the passage is how Elisha's efforts do not fully succeed at first. He must engage in the rather odd practice of laying on the boy "mouth to mouth, eyes to eyes, hands to hands" a second time. These anatomical regions of the body signify *function*, the mouth associated with breath, the eyes with alertness and awareness, and the hands with strength and purposeful movement (Cohn 2000). Curiously, Elisha's first attempt only establishes warmth in the body, which is ambiguous at best. We do not know if this warmth was accompanied by other functions, like a heartbeat and hypothalamic functioning — a brain function associated with

temperature regulation — but if they were, it does not seem to matter. Elisha does not rush out to the mother declaring resurrection nor does he seem to think he achieved as much. Rather, he pauses to pace and he tries again. Elisha's second attempt produced seven "sneezes" in the boy who then "opened his eyes" — signifying the return of self-initiated breathing and alertness — two unambiguous signs of life. Elisha then called the mother.

At this point, I should disclose that I believe "brain death" can be validly determined by criteria that indicates the loss of the "brain as a whole" (Pallis and Harley 1996; Bernat 2022; 2023). I also believe that these criteria are best described as "neurorespiratory criteria" which relate the brain functions that examiners test for to the body's material capacities for consciousness and respiratory drive (Omelianchuk et al. 2022, Greer et al. 2023). I therefore reject the "whole-brain" formulation, which implies that every function of the brain matters. I will provide some reasons for this later while acknowledging that not everyone sees it the way I do.

For now, I want to focus on the curious "in-between" state that the "brain dead" state presents to observers. It is a weird state somewhere in the shadowlands between those that present clear signs of life and clear signs of death (McGee, Gardiner, and Jansen 2023). Anyone who has witnessed a "brain death" exam will know how odd and ambiguous the body is in this state. The eyes, which must be pried open, do not move when they are swabbed with cotton or when the head is turned abruptly from side to side. There are no signs of agony in response to pinches, pressure points, or ice-water dribbled in the ear. No drive for breath occurs when the ventilator is disconnected for 10 minutes. If it is possible to survive after "giving up the ghost" the "brain dead" body is what it looks like.

Elisha confronted something similar, a confounding state that does not clearly indicate life or death in the usual sense of the words. The boy's body was warm, perhaps maintaining homeostasis through gas exchange, preserving cellular function and hemodynamic stability. One might think an "integrative function" is present (Sulmasy and DeCock 2023; Austriaco 2016a). But there is nothing else. No sign of breath, arousability, or awareness. Elisha believes he must intervene again. Some, like Spurgeon, draw a moral lesson, that failure in the first attempts of ministry is no reason to give up, for God will reward the faithful in their efforts to minister to others (Spurgeon 1897). I am not sure that Elisha's first attempt was a failure, exactly. The broader context of the story reveals what failure looks like, as Gehazi was not able to make any difference to the boy's state. While Elisha made some progress, he could not call it a success either. A question lingers: *what if Elisha's second attempt had failed?* What if all he could do was achieve warmth in the body? A similar question faced intensivists in the 1950s, 60s, and 70s when mechanical ventilation supported the circulation of patients with necrotizing brains. It is precisely the question stunned family members face today when their loved ones are declared dead because they are "brain dead." Aren't they warm to the touch? Aren't they just sleeping? Why can't they wake up? Is grief appropriate? We have been struggling to answer these questions ever since. I am not sure if it is comforting, but it is relatable: one of God's greatest miracle workers felt the same sense of bewilderment in the face of such confusing results.

One issue in the background of the so-called "accepted medical standards" for determining death is the "there isn't anything more we can do" criterion. Whether or not we think "brain death" is death, it remains a clinical endpoint that always raises questions that fall into the categories of "futility" or "the allocation of resources." The

pressure to withdraw ventilatory support is enormous and only those who stubbornly believe that recovery is still possible resist it. In other words, nothing but prayer and trust in God seems to be the appropriate response to the situation. At least for a time (Omelianchuk and Magnus 2022).

Working-togetherness

The third thing to notice is that the activity of the eyes, mouth, and hands are to be taken together. The metaphors of the Hebrew text are opaque to us as all metaphors are, but they identify something primitive and mysterious that is nonetheless perceptible in the phenomenon of life. To be alive is to be engaged in an activity characterized by a sensitivity to the environment and an inner need, which directs effort to act on the environment to meet those needs. When I read this passage, I think of the writings of Hans Jonas, Leon Kass, and the 2008 "white paper" on controversies over determining death from President's Council on Bioethics, all of which emphasize the "working-togetherness" of an organism's aggregate parts to unify into the act of self-preservation (Jonas 2001; Kass 1995; President's Council on Bioethics 2008).[4] As Alan Rubenstein, the drafter of that white paper, explains:

> The body with total brain failure ["brain death"] is disengaged from the world in a significantly more profound way than of any other human injury. Colloquially speaking, the body is "closed for business"; it is no longer engaging in the most fundamental work of living things, and observers recognize the profundity of this fact even if they don't articulate it in just this way (Rubenstein 2009, p. 42-43).

The upshot is this: If the capacity of an organism to engage in self-directed action characterized by need-driven exchange with the environment is lost, then the capacity

[4] The Council's paper was a response, in part, to Shewmon's (Shewmon 2001) ideas about integration.

for it to be alive is lost. This capacity is lost when the clinical criteria for "brain death" are met — when, absent confounders, one sustains a brain injury that leads to the permanent loss of (1) the capacity for consciousness, (2) the capacity to breathe spontaneously, and (3) the loss of all brainstem reflexes. Therefore, death can be declared. This reasoning is consistent with a brief remark in the President's Commission's 1981 report *Defining Death* which says, "What is missing in the dead is a cluster of attributes, all of which form part of an organism's responsiveness to its internal and external environment"(President's Commission 1981, p. 36). Whatever we might be able to achieve insofar as we maintain the "internal environment" of the body through critical care technology — mechanical ventilation, continuous renal replacement therapy, extracorporeal membrane oxygenation, blood pressure support, tube feeds, and foley catheters — we have learned it is not enough to restore the capacity for this primitive, end-directed agency to interact with the external environment. For these reasons, such a body can be declared dead (Omelianchuk 2021).[5] I know others disagree (Shewmon 2024; Sulmasy and DeCock 2023; Shewmon 2022; Sulmasy 2019), but the fact remains that the best we can do is maintain a state of the body that is utterly confounding. This is what medical technology often does for us: it fails to clarify the most important things in life; rather, it confuses them. Those who believe "brain dead" patients are alive must either pace and pray, seeking God's help for further recovery, or resign the body to a more natural fate. There is, quite literally, nothing more that can be done.

[5] Recently, the American Academy of Neurology recognized these criteria in their updated guidelines (Greer et al. 2023).

The problem of disaggregation

Now that I have wadded into these controversial waters, let me take a step back to say something more unifying: the practice of determining death by neurological criteria emerged in response to a deep and profound problem caused by advances in critical care medicine that remains with us today, that is, the problem of disaggregating the functions of different parts of the body from the whole. Yes, some of this was driven by organ transplant interests but those interests are also a symptom of the disaggregating, if not reductionistic, spirit of modern medicine. While it is common for bioethicists to believe that "brain death" was invented to expedite organ donation, it must be remembered that transplant medicine was highly experimental at the time, not the effective therapy it is today. And while the ability to transplant the heart was no doubt dazzling at the time, the stubborn problem of rejection was not overcome until the 1980s. Before then, transplantation offered little benefit and poor outcomes made its purveyors disreputable in the eyes of their medical peers in ways we have largely forgotten (Mezrich 2019). The problem of disaggregation caused by modern intensive care between the tripartite vital activity of the heart, lungs, and brain was more salient and more profound to examiners. The person who noticed this problem and thought most instructively about it from a Christian perspective at the time was none other than Paul Ramsey.

In the second chapter of his classic book *Patient as Person*, Ramsey provides a searching, if it at times complicated, connection between what he calls "the primitive psychophysiology of the Bible" with "the definition of life in terms of heart and lungs and brain" and the Harvard Ad Hoc Committee's recommendations for "updating of the clinical tests for determining that a patient has died" (Ramsey 1970, 60). The brain,

according to Ramsey, does not have the advantage of the heart and lungs insofar as its permanent loss of function is not easily determined. It takes no special training to notice a lack of pulse or lack of breath. Nonetheless, the brain is vitally important to the functions of heart and lungs, for if it fails, then spontaneous breathing ceases, and so too, shortly thereafter, the heartbeat. Ramsey believes we are hoodwinked by the ventilator into thinking that the heart beats "spontaneously" in the "brain dead" body. Indeed, he believed it beats "artificially." The sense of "spontaneity" he uses here is obscure. Isn't someone alert and oriented with a high spinal cord transection in the same situation? Still, he is on to something. A charitable reading of his argument is that the heartbeat *qua* decisive sign of life is confounded in the "brain dead" body because its function is only a secondary effect of the lungs being filled with air at the behest of the ventilator, and not at the behest of the body which, because the brain has failed, shows no interest in the need for oxygen whatsoever.

One must remember, Ramsey is not interested so much in providing an analysis of death as a philosophical concept. Rather, he seeks to interpret the practical art of medicine insofar as it seeks to validate the results of bedside tests that would serve to determine death. While he is aware that people define death conceptually in terms of the loss of consciousness only, he did not think the Harvard criteria entailed *only* that concept. Rather, they were consistent with a plurality of concepts, including what he took to be the Biblical one, which, to his mind, was consistent with the intuitive idea that death is the loss of the integrated functioning of the organism as a whole. This is why he writes, "We should therefore take the current discussions of death to be practical proposals for revising the procedures for stating that death has occurred, and not as discussions of the theoretical meaning of death" (Ramsey 1970, p. 66).

This is wise advice. It illuminates the recent discussions over what the law should say about what counts as legal death (more on these discussions below). Ramsey was one of the first to disentangle three levels of analysis in thinking about death. First, there is the philosophical concept of death, which functions at a high level of abstraction. At this level, questions about whether death is a process or an event are relevant as are questions about whether it should be defined in terms of the loss of the soul, the organism as a whole, or the so-called "person." Answers to these questions are removed from empirical considerations. Second, there is the criteria for determining that death has occurred. This is an empirical level that directs examiners where to look to determine death. Lastly, there are the tests operationalized in a step-by-step fashion that, if satisfied, justify a declaration of death. The gap between what philosophers of medicine and bedside examiners are concerned with can be quite large and confusing if this framework is not kept in mind. Yet he does not think one must get the concept correct first, then develop criteria, and then tests. Rather he thinks the process is more cyclical; one can start with observations, develop a theory to explain them, and refine tests along the way to further specify what ought to be observed when determining death. Ramsey cautions that the definition of what death is should not be confused with the methods by which it is determined. His sense of practicality shines through when he says the primary concern of medicine is not to settle the "meaning of death" but to "establish agreed-upon procedures for stating death has occurred"(Ramsey 1970, p. 66). With respect to the Harvard criteria, he wrote:

> It is an updating of the meaning of death only in the — medically quite proper — nominalistic sense that death means the procedures for stating that it has occurred. This is undergirded by a *concept* that death means a permanently nonfunctioning brain. But the *characteristics* of this state of affairs are what is

> chiefly in view, and this leads to the procedures proposed for stating that a man has, on the committee's view of what death is, actually died (Ramsey 1970, p. 94).

Thus, Ramsey advises nominalism and tolerance for other philosophies of death in the practice of medicine so long we are able to account for the name given to death in a way that is biologically coherent, ethically sound, theologically meaningful, and medically practicable.

Nagging questions

What, however, should be done for those who do not believe death can be determined by neurologic criteria? Ramsey does not consider this question yet it concerns a growing number of clinicians, philosophers of medicine, and Christian theologians. Some call for an opt-out clause to be added to the law because, in their view, "People have a right to not have a concept of death that experts vigorously debate imposed upon them against their judgment and conscience" (Shewmon 2021). But if people have such a right, then it only generates a duty in the team to not declare death on neurologic grounds, which is nevertheless consistent with the team's authority to unilaterally withdraw ventilatory support and allow the circulatory-respiratory criteria to be fulfilled. The right does not justify continuing support — a right to die on the vent, so to speak — more argument is needed to establish that much (Omelianchuk and Magnus 2022). Another thing is that given the entanglement of "brain death" with organ donation, it is incumbent upon dissenters to clarify the circumstances under which they are willing to donate so that they will act consistently with the dead donor rule, either allowing for donation after circulatory death only or not at all. Creating an "it's up to you" policy renders the moral status of the "brain-dead" body ambiguous which has

implications for the moral coherence of homicide law and the dead donor rule. Christians ought to consider these broader implications for the common good and their solidarity with others.

Perhaps more than anything, Christians, along with everyone else, should insist that the so-called "accepted medical standards" for determining death be rigidly followed. A disturbing amount of variation and deviation from those standards exists in medical practice (Greer et al. 2016), which may very well reflect a "close enough" approach to determining death, which is lazy, sloppy, and apathetic towards the person being examined. If those standards are not met, a declaration of death risks being invalid, which further risks death by organ removal if the patient is a donor. The story of Ryan Marlow, a North Carolina pastor who was wrongly declared brain dead, and who displayed signs of life before his "honor walk" to the operating room is a cautionary tale (Court 2022). When I spoke to Ryan's spouse and decision-maker, Megan, about the ordeal she told me the whole process reflected a lack of respect for life and a failure to clearly communicate how things were done. This lack of respect, at the very least, translates into a lack of care in the examination process, which must be confronted and resisted.

Final thoughts on moving forward

Between 2021 and 2023, the Uniform Law Commission deliberated over whether to update the Uniform Determination of Death Act, which, again, reads:

> An individual who has sustained (1) either irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards.

Among the many issues that were considered was whether to change the law's language from "irreversible" to "permanent", whether "all functions" of the brain should be changed to some specified list of functions, whether consent for a "brain death" examination is needed, whether a family is entitled to a "reasonably brief" period of ongoing ventilatory support after a death declaration in time to gather at the bedside, and whether an exemption from being declared dead by neurologic criteria should be allowed. The debate among the Observers in this process was acrimonious and the Commissioners felt stuck, unable to establish much consensus, and "paused" the process indefinitely in the fall of 2023.[6] Christians were part of this process, taking up contrary positions. As an active Observer who was invited to make comments on the various issues, it pained me to feel at odds with such thoughtful people. Given the hesitancy of the Commissioners to recommend anything to the states to vote on that would cause more division and variation in the law, I am not sure anything will substantively change, but it would be foolish to make a prediction. Like any concerned citizen, Christians should be active in their local context about these issues and advocate for what they believe is right.

That said, my hope is that, in the clinical context, whether as a provider or as a patient's family member, we would know that our view of life and death must be consistent with the hope we have in the resurrection, which allows us to accept the end of our earthly life sooner rather than later, that pacing and praying is appropriate but

[6] Judge Thumma wrote by email to the Commissioners and Observers (September 22, 2023): "In consultation with ULC leadership, and based on feedback from the first reading and our efforts to date, we have decided to pause the rUDDA effort. The result of this pause is that, although we will continue to hope mid-level principles will become apparent, no further drafting committee meetings will be scheduled at this time. We will continue to monitor developments in this area, and if we see promising signs of a possible path forward toward a widely enactable revised act, we can then reassess having the committee resume its work."

only for a season, that our bodily life is more than the sum of its parts, and that the "patient as person" includes more than thinking of the patient as simply an "embodied mind" or a mentally constructed "person." Whatever disagreements may persist in how we define and determine death, we should remember the words of St. Paul for how we are to understand the meaning of life and death: "If we live, we live for the Lord; and if we die, we die for the Lord. So, whether we live or die, we belong to the Lord. For this very reason, Christ died and returned to life so that he might be the Lord of both the dead and the living" (Romans 14:8-9).

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