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The Redefinition of Death and Creation of New Biopolitical Subjects

A 6 year-old patient is lying in bed at a hospital suffering from kidney failure. Doctors have given a bleak prognosis of two weeks unless a matching kidney can be found before the two weeks are up. A few doors down, a woman is visiting her husband who has just been declared brain-dead after being in a coma for two months. Doctors ask her if she would like to keep him on life support, or perhaps let him go and allow them to harvest his organs to potentially help other patients. The woman is not informed of the following information, but his kidney is a match for the 6 year old down the hall. Should the woman keep her husband on life support in hopes that he might come out of his coma in the future, or should she allow his organs to be harvested and donated to those in need?

Situations like this are not only the subjects of popular medical television shows, but also occurrences that happen every day. Less than a century ago, no one would ever be faced with such a difficult decision. Only recently have developments in organ transplant and medical life-prolonging technology resulted in the introduction of the concept of brain death. This paper seeks to investigate the effects of these developments in biotechnology on conceptions of life and death in the United States. Additionally, the bioethical and biopolitical implications of these medical developments will be assessed based on Foucault's and Agamben's theories on sovereignty and governmental roles in biopolitics.

Organ transplant technology was first introduced in the 1950s as developments in immunology were used to facilitate kidney transplants. However, the transplant technology had a high failure rate and did not become a viable option until the 1970s when immunological responses were sufficiently suppressed (Jones 65). Once this was

accomplished, physicians realized that if transplantation was to be made available on a regular basis, a sufficient supply of organs would need to be generated. Live tissue showed a higher success rate in transplantation therapy than tissue from cadavers, leading to increased interest in comatose and vegetative patients being kept ‘alive’ by life-support technology as a source of live organs.

Coincidentally, life-support technology was developing during the same time period in which these advances in organ transplant technology were being made. The first instance of medical life-prolonging technology was the development of breathing machines such as the Iron Lung in the mid 1900s. These artificial ventilation systems maintained vital respiratory function in patients who would otherwise face certain death (Lock 58). By the 1960s, intensive care units were developed in hospitals, equipped with such life-sustaining technologies as feeding tubes, medication administrating machines, and defibrillators to keep patients alive when they could not perform these functions for themselves. The profound impact of these new medical technologies on social understandings of life and death is perhaps best described by the following line printed in *Literary Digest* magazine in response to the development of defibrillators: “it might be possible to recall a man to life—to raise him (in a manner of speaking)—from the dead” (Lock 60). However, for those interested in organ transplantation, the critical question to be asked was, are the people kept ‘alive’ solely by life-support technology truly alive?

As mentioned earlier, the concurrent developments in organ transplant and life-support technology changed understandings of life and death in the United States. The boundary between the two states of being was no longer clear as the biological criteria for death changed with advances in medical technology. In the 1960s, before significant

advances in life-support technology had been made, death was recognized as the cessation of heartbeat and breathing (Jones 65). However, as medical technology developed that could stimulate the heart to beat and perform respiratory function for patients who lost such capabilities, the definition of death changed to entail either brain stem or whole brain death (Jones 65). This concept of brain death could not exist without the introduction of life-support technologies: without these machines, brain death would result in the loss of all biologically vital function and ultimately in the absence of heartbeat and breathing, the previous criteria for death. With the new concept of brain death, physicians were faced with the issue of how to proceed with brain-dead subjects: because they were neither people nor cadavers, these patients were morally ambiguous (Kaufman 330). Should resources be used to maintain their vital functions, or should these resources be allocated elsewhere to non-brain-dead patients? That is, what moral obligations do medical professional have towards brain-dead subjects?

The topic of brain death grew quite controversial as it came to be known as an "almost-but-not-quite-death" (Kaufman 330). The long-term comatose, severely demented, unconscious, and minimally conscious hovered in a state between the living and the dead. Because of this uncertainty, the concept of "personhood" also had to be adjusted (Jones 68). Whereas previously personhood was determined to be an intrinsic attribute of all human beings, the appearance of the discussed medical technologies altered this idea to focus on the state of a person's brain. In the United States, personhood was shaped by Judaeo-Christian traditions as man's dominance over God's creations: more specifically, nature was seen as a resource to be exploited in man's interest (Jones 69). Based on this idea, modern conceptions of personhood make the

requirement that one must have the psychological capacity to make decisions in order to qualify as a human being. Thus, the brain-dead do not qualify for personhood: although their bodies may still be functioning, their minds, understood to be a metaphor for their souls, are no longer present and therefore do not define them as people (Jones 70).

The dehumanization of patients in intensive care units furthers this idea of the brain-dead as less-than-human. Although unintentional, the presence of so many machines, tubes, lines, and leads attached to the patient, makes the patient become a sort of cyborg—while he may not be described as "alive" at this point, the fact still remains that he would most certainly be dead without these technologies. In addition, the subjective experience of the patient is no longer a factor, as his "personhood" is replaced by a medical narrative composed of graphs, traces, and data from the numerous machines monitoring his health (Lock 63).

The bioethical problems of how brain dead patients should be dealt with and viewed are closely linked to the biopolitics created by the presence of life-sustaining technologies. To understand the biopolitics involved in the discussion of brain-dead subjects, I will review the theories of Foucault and Agamben and apply each of these theories to the brain-death problem to understand how developments in medical technology have defined a new set of biopolitics,

Foucault's theory focuses on changes in how the government has approached the power over life and death. First, he argues that the ancient practice of taking life and allowing subjects to live has been replaced by a power to "foster life or disallow it to the point of death" (Foucault 138). This point is especially relevant in the case of the brain dead because the removal of such patients from life support technology is exactly a

"disallowance" of life. The life of the patient is not being taken. The dying process that was being prevented by biotechnology is simply being allowed to proceed in the absence of life-support technology.

Second, Foucault suggests that the idea of power over life is based on the idea of the body as a machine that the government can discipline, optimize, and extort (Foucault 139). While a brain-dead patient still has a functioning body in the sense that the body's vital functions are being maintained, the patient is not a machine that can be optimized or extorted by the government because he is unresponsive. In effect, he is no longer useful to the government. It seems appropriate, then, for brain-dead subjects to be considered "dead" in biopolitics. Indeed, this was established in the United States through the Uniform Determination of Death Act of 1981 in which lack of "neurological integration" establishes a subject as "no longer a functional or organic unity, but merely a mechanical complex" (Jones 67). This example shows that the brain-dead are still considered objects governed by biopolitics, but they are not biopolitical subjects, or citizens, themselves.

A third point Foucault proposes is that biopolitical subjects are brought into being through the workings of biomedical regimes of power (Kaufman 329). This is applicable in the case of brain-dead subjects because, as mentioned previously, there was no such thing as brain death before the development of biomedical technologies that performed vital bodily functions for patients who could no longer carry out these functions for themselves. Foucault takes this argument further in suggesting that life itself is a political object (Foucault 145). He suggests that not only does life make one a biopolitical subject, it also gives one such rights as the right to life, to one's body, to health, etc. (Foucault 145). Thus since brain-dead patients are not considered to be alive, they do not

inherently have a right to life, to their bodies, to health, etc. We see this in the modern medical system as the decision to either keep brain-dead patients on or remove them from life support is left to close relatives or friends. In effect, brain-dead patients do not have sovereignty over their own fates.

Agamben's biopolitical theory is largely concerned with the idea of sovereignty and the biological prerequisites a subject must have to enter the political sphere. Agamben's first proposal is a distinction between bare life, termed *zoë*, and politically or morally qualified life, called *bios* (Nikolopoulou 124). He writes that the law has been able to actively separate political beings, or citizens, from bare life, or bodies, from antiquity to modernity. However, bare life is a necessary prerequisite for the morally qualified life (Nikolopoulou 124). The brain-dead have bare-life, and therefore automatically qualify for political life. This is a fundamental difference between Foucault and Agamben: while the brain-dead are not considered biopolitical citizens under Foucault's theory, they are considered citizens and therefore are protected by biopolitical laws in Agamben's theory

However, at the same time, Agamben's theory brings up the question of who has bare life worthy of political life. The brain-dead *qualify* for political life, but they do not necessarily *have* this power. This is the different between being protected by biopolitical laws, and asserting one's rights under the same politics. Agamben proposes that biological life, *zoë*, "lays itself bare before the authoritative structures of sovereign power" (Nikolopoulou 126). The ultimate criterion of sovereign power rests in the decision over the protection or destruction of a human body. This is represented in considerations of the brain-dead by the protection of the human body through life support

technologies until tests can be run to declare the subject brain-dead, a point after which destruction of the human body becomes a viable option left up to others to decide.

Biotechnical innovations continue to be made every day, allowing us to defy death in ways unimaginable to our ancestors. As these developments are made, we create new states of being, such as the brain-dead state, that not only require us to re-evaluate our conceptions of life and death, but also often create new biopolitics to govern subjects occupying these states of being. The very nature of biotechnological progress necessitates these changes, but previous theories on bioethics and biopolitics can be applied to help us determine how to deal with these new ideas—at least, thus far. As mentioned in the first sentence of this paragraph, biotechnical innovations make possible ideas that were previously unimaginable: who knows what biopolitics will be developed in the future as a result of such advancements!

Resources:

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