

Ethical Criteria for Death for the Purpose of Organ Retrieval

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Abstract

Advances in medicine have given us the technology to transplant life sustaining organs from deceased persons to those in need of them. It also raises ethical questions about the criteria of death used to determine that the donor is indeed dead prior to removal of these life sustaining Organs. Consideration is given to the two criteria used to determine the physical death of the donor along with consideration of the role consciousness plays in determination of death. The author concludes that the criteria are vague and specious and largely unethical as employed throughout the world, and that, as Christians, we have a unique challenge to oppose the secular views now dominating medical science.

Ethical Criteria for Death for the Purpose of Organ Retrieval

Medical advances in recent years have raised questions about the ethics of many aspects of this New Medicine. These concerns continue to grow in both numbers and urgency. Procedures for organ procurement for transplantation is one of these areas.

The basic ethical concerns of the act where one individual benefits from the death of another has itself been answered. Organ donation has been deemed morally acceptable under certain well defined conditions by even such rigorous scrutiny as the Catholic Church. The National Organization of Transplants claims on its web site that “All major religions approve of organ and tissue donation and consider donation the greatest gift.” (NOT, 2003) and the Catechism of the Catholic Church states that “dangers and risks to the donor are proportionate to the good sought for the recipient. Organ donation after death is a noble and meritorious act and is to be encouraged” (Catechism, 1997 paragraph 2296). Concerns about the status of the donor, however, remain, and recent developments in the procedure of procurement of organs now causes concern.

According to the various transplant groups, the shortage of organs for transplant is “critical” in the case of perfusing organs such as heart, lungs, kidney, and liver. Bone, skin, and corneas are more readily available. There are less restrictive criteria for these organs and they can be stored for longer periods of time while matching the donor and recipient. (MGH Hotline, 1999, The Reporter, 2001, National Foundation of Transplants, 2003)

But perfusing organs such as the heart, liver, and lungs need to be preserved in a viable state from harvest to transplant time. In order for the organs to be usable, the least possible time

for interruption in perfusion is a goal because these organs rapidly deteriorate in the absence of perfusion.

In the U.S., the HHS Advisory Committee on organ donation released recommendations in 2003 for increasing organ transplantation. In February of 2005, AMNews happily reported a 10.8% increase in organ donations in 2004, but stressed that a collaborative effort is needed to continue that increase (JAMA OnLine, 2005).

The worldwide market for organs has become a lucrative business. Many are aware that there is a black market for organs in some third world countries. In China, prisoners are reported to be selected for death based on the suitability of their organs for transplant (Mufson, 2001). An August 22, 2006 St. Louis Post Dispatch story call it “no secret that many of those organs have come from executed prisoners. But there is growing evidence that many are now being obtained from people whose only crime was to practice a form of meditation and exercise called Falun Gong.” (Editorial Commentary, 2006)

Back to the U.S., in order to allow for harvesting of organs before deterioration, an ad hoc committee at Harvard in 1968 re-defined the criteria of death as the loss of function of the entire brain, now commonly referred to as “brain death”. (Valko 1 2002) This method of determining death remains controversial and some ethicists, particularly Catholic ones, still reject this definition. In response to growing ethical concerns about diagnosis of death in patients for the purpose of harvesting organs, the bioethical think tank, the Hastings Center, proposed the Dead Donor Rule in the late 1960’s stipulating, among other things, that donors cannot be killed for the purpose of obtaining their organs. (Baruch 2003) Without identifying a criteria of death, it stipulated that life-sustaining organs must never be removed before the donor is declared dead.

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For the purpose of obtaining life sustaining perfusing organs, brain death, however loosely one interpreted the criteria, proved not to meet the demand for transplantable organs. The numbers of patients, usually trauma victims, was simply not providing enough organs. One solution to the problem was the advent of a procedure known as “non-heart beating organ donation”, NHBD. (Also known as “donation after cardiac death, or DCD, in Great Britain) as reported in NewScientist. (Nowak & Geddes 2006) The same NewScientist article reports that at a July 2006 meeting in Boston, Massachusetts, doctors at the World Transplant Congress were told that the pool of available organs in the US could increase by up to 20 per cent if NHBD was adopted more widely - enough to treat 6000 people in the US who die each year while on organ waiting lists.

The procedure for NHBD was devised at the University of Pittsburgh in the 60's. One source claims that the procedure was done for kidney harvesting as early as 1951 (Mozes 2000). The procedure allows for organs to be taken from people who are not brain dead but whose families agree to withdrawal of ventilators.

Using the cardiopulmonary determination of death as defined by the Pittsburgh Protocols, doctors give ventilator patients deemed 'hopeless' Heparin and Regitine (to prevent blood clotting and inhibit release of catechoamines) to help preserve organs, then take the donor to the operating room where the ventilator is removed. Feeling for a pulse and waiting for respirations to cease, the doctors declare the patient dead after two minutes and begin harvesting the organs. Initial organs removed were the kidneys, but other major perfusing organs such as pancreas and liver are now removed for transplant.

What I propose to examine in this paper is the criteria for the medical diagnosis of death in order for the organ harvesting to proceed. Is it ethical to remove organs from a patient under the current criteria for death, either brain death or cardiopulmonary? If not, what should the criteria be?

The Criteria

In the case of **brain death**, we know that there are ethicists who object to this criteria and, therefore, to the harvesting of organs from persons with this diagnosis. They object to the criteria for a variety of reasons.

A.M. Capron in the *New England Journal of Medicine* called brain death criteria “Well settled and persistently unresolved” (Capron 2001) and Truog and Robinson note that the concept of brain death “fails to correspond to any coherent biological or philosophical understanding of death.” (Potts & Evans 2005). A *Playboy Magazine* article even weighs in on the issue, calling the diagnosis of brain death “expedient medical fiction” (Salerno 2003). And among those who accept this criteria, there is wide latitude as to what determines brain death (Turner 1999, Byrne 1988). But, as a result of the Uniform Definition of Death Act proposed by National Conference of Commissioners on Uniform State Laws to define the legal meaning of death in 1981, in all states now, death can be legally determined either by the traditional irreversible cardiac death or by brain death. (Baruch 2003)

Although coming from two differing perspectives, Jay Baruch echoes the Truog and Robinson claim that it fails to correlate with any biological or philosophical understanding of death and Baruch also questions whether death of the brain equates to death of the organism (Baruch 2003, Truog & Robinson 2003). Allen Turner deals with the concept of “neomorts”

introduced by psychiatrist Willard Gaylin in a 1974 article in *Harper's Magazine* which defines a neomort as a new kind of cadaver that would have the legal status of one who is dead but with none of the qualities one normally associates with death. These “newly dead” would be “a warm, respiring, pulsating, evacuating, and excreting body requiring nursing, dietary, and general grooming attention (brain dead). These ‘living cadavers’ would then be stored in ‘neomoratoria’ for organ transplantation, medical and nursing education, and drug research.” While this all sounds like science fiction to the Christian or even to the non-Christian with an innate sense of the dignity of the person, the concept is appealing to some in the scientific community. Turner links this concept to an acceptance of the diagnosis of brain death (Turner 1999).

Potts and Evans argue against the diagnosis of brain death in a lengthy article in the 2005 *Journal of Medical Ethics*. They dispute the claim of the criteria that the removal of vital organs from those who are declared brain dead or other classes of comatose patients is morally equivalent to “letting nature take its course”, arguing that, unlike “allowing to die”, it is the removal of vital organs that kills the patient, not his or her disease or injury. (Potts & Evans 2005). Once they establish that the criteria used to diagnose death are not valid, they argue that removing vital organs from living patients is immoral and contrary to the nature of medical practice.

F. J. Leavitt cites a survey reported in the Hastings Center Report in 1997 that found that one third of physicians and nurses do not believe brain dead patients are actually dead. He uses that as an argument for that the position that we are killing patients for their organs should be heard (Leavitt 2002). (However, although he holds that brain death is not death, Leavitt argues

In his paper for the harvesting of organs from a volunteer who requests to be anesthetized for the purpose of taking his organs even though the patient admits to being under psychiatric care!)

There is consensus that the diagnosis of brain death can be interpreted in a variety of ways (Turner 1999, Byrne 1988). A web search located a MEDLINE compilation of recent reports concerning the determination of brain death that printed out to 17 pages, and this was a review of *abstracts*. Clearly there is great diversity of opinion as to how the written criteria are to be interpreted. As with all other aspects of the discipline of medicine, this aspect is an art that cannot be neatly packaged and applied broadly. This leads to the human tendency to push the criteria in the direction which best suits the agenda of the person interpreting it. The driving force for employing the brain death criteria is the need for organ procurement.

Baruch claims that the Harvard criteria is operationally confusing describing “irreversible coma” as brain death. But the clinical picture is one of heart beat, skin warm and well perfused, breathing, functioning vital organs, capable of somatic growth, and capable of reproduction. He calls it a conceptual disarray, that these patients are perhaps, terminally ill, but not dead. He goes on to question why brain dead persons are considered dead when they receive certain “treatments” (generally based on preserving the organs for transplant), may receive CPR if the heart stops, and receive anesthesia prior to procedures. Ambiguous language is used depending on the circumstance from “more than a corpse”, to a beating heart cadaver, to a neomort. Baruch goes on to point out that there is tension between maximizing organ viability and satisfying the dead donor rule.

Prior to his death, Pope John Paul II released a letter to the Pontifical Academy of Sciences calling for a task force to set up more precise means of establishing that the donor is

dead before vital organs are removed. In it, he reiterated the Catholic Church's consistent support of the practice of transplanting organs from deceased persons, but continued that organ transplants are acceptable only when they are conducted in a manner "so as to guarantee respect for life and for the human person." Regarding the diagnosis of brain death, John Paul II points out that it is a term for which there is no universally accepted definition and asks that one be sought, promising the support of Vatican officials in this pursuit (John Paul II 2005).

The brain death concept of death is an implementation of the utilitarian ethic satisfying the goal of the greatest good for the greatest number. This utilitarian view causes other dissenters of the criteria to object. There is no consideration of overriding principles about the inherent dignity of the human body as created in the Image of God and raise legal issues about the civil rights of these individuals to be treated as living members of society with inherent worth, not as a commodity because of the value of their organs.

Non-heartbeating Organ Donation got off to an obscure start in the 60's. But following a "60 Minutes" TV program which did a segment on NHBD at the Cleveland Clinic in April of 1997, there was a general public outcry over the procedure. The Institute of Medicine (IOM) subsequently studied the issue (Kolata 1997). The IOM did not address all the problems with the procedure but, in spite what the Institute called "problems" in some cases, it declared NHBD ethical. The study called for more research and the setting of national standards for NHBD and recommended the waiting period before harvesting be lengthened to five minutes (IOM 1997). Media attention abated and most people are still not aware of NHBD.

Already by the year 2000, an IOM follow up report found that almost none of the paltry recommendations it had made in 1997 were being employed (IOM 2000). There was not even

consensus on whether conscious people on ventilators should be allowed to donate organs using NHBD. Appallingly, the IOM continued to encourage all organ procurement organizations to use NHBD. By 2004, it was estimated that almost ½ of all transplant centers have used NHBD at least once (Valko 2 2005).

The procedure is now divided into two situations and referred to as “controlled” and “uncontrolled”. In the controlled NHBD, the decision is made to withdraw the ventilator and the patient is taken to the operating room for withdrawal, death, and harvesting as previously described. In the uncontrolled situation, the patient suddenly dies and resuscitation is unsuccessful. An emergency procedure is instituted to preserve the organs and permission for harvesting sought by survivors. The emergency procedure consists of femoral cannulation of the decedent followed by the instillation of cold fluid to preserve the organs.

The Pittsburgh Protocols were re-defined in 1993 and address a variety of aspects.

Baruch enumerates and critiques each briefly. They are reviewed here: (italics are mine)

- In what Baruch calls a critical symbolic leap, the protocol does link the planned death of one person to the procurement of organs for another. *(This sets up acceptance of the concept that the life of one individual is deemed more important than another and justifies the planned death. It promotes the mindset that John Paul II refers to as the “culture of death”).*
- Specifies the controlled time and place of death--the OR. *(This deprives both the family and the patient of the opportunity to spend the final minutes of the patient’s life together in mutual comfort and support.)*
- Calls for 2 minutes of circulatory arrest before death certified *(in spite of the IOM recommendation of 5 minutes)*

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- Specifies that families must decide to withdraw life support (*but it does not address fully informed consent or coercion*)
- Death must be declared by MD unaffiliated with procurement (effort to avoid conflict of interest--meets with only marginal success)
- Calls for a clear separation between the medical team treating the patient and the organ recovery team
- Specifies documentation requirements for auditing purposes
- Indicates that the lay community was involved in the policy development
- Requires ethics consultation before procurement

A Kennedy Institute of Ethics report in 1995 indicated that several centers are without any policies addressing key features such as timing of death after cardiac arrest; conflict of interest avoidance; only three centers allowed family members to be present at the time of death; more than half did not use ethics committees or consultants during protocol development; and it questioned whether all of the patients were actually dead prior to initiation of organ harvesting (Spellman 1995).

The 20 Minutes program exposing practices in NHBD followed this Kennedy Report by two years, so the problems associated with it persisted even after the Kennedy report. As to the Kennedy Report concerns about whether the patients were actually dead prior to initiation of harvesting, www.lifesite.net carried an article in September of 2003 reporting that surgeons in Russia are removing kidneys from homeless people in illegal organ-harvesting operations. The spare parts are reported to be worth as much as \$40,000 each. In defense of the practice, one of the surgeons was reported as saying that the donors “are ‘done for’ anyway, maybe they could live another three or four days.” The article was entitled “Russian Surgeons Removing Organs Saying Patients Almost Dead Anyway” (LifeSite.net 2003).

One ethical consideration is the selection of the donor for transplant. There are documented instances where, in the rush to procure organs, family members are pressured to agree to organ donation and urged to proceed before the patient's given time for an adequate diagnosis and/or prognosis can be made, particularly in the instance of traumatic brain injury. The young patient in particular has been known to recover fully after an extended period of time and others recover sufficiently to appreciate the effort made to save what is left of his or her life. There have been recent reports of "awakenings" of patients in previously diagnosed persistent vegetative states for periods approximating 20 years. Certainly where life is involved it would not be asking too much to wait and see how the patient will respond once the brain swelling has subsided.

The most callous and base consideration but one which drives most of the push to retrieve organs is that of cost of delivering care to those individuals in a variety of medical conditions. Health care costs have become a prime consideration for who should receive what treatment. It is financially beneficial for the treating facility to discontinue treating a long term full care patient than to continue the treatment of the one in some stage of unresponsiveness. This motive is, of course, not apparent or even discussed as a consideration in the clinical setting, but it has been alluded to as a consideration when policies are made or when there is legislation considering the issue.

Most institutions now have what is called "futile care" policies which dictate what services will be provided for patients in their facilities. In Texas, a state law insures the right of the institution to deny treatment to those in various states of debilitation (Chapter 166 Texas

Health and Safety Code). And “futile care” becomes another dehumanizing term to describe a living

human being. Where the institution, with the complicity of the hospital ethics committee, has termed the care futile, treatment can be denied and permission sought for NHBD if the patient’s organs are in such condition that they are transplantable.

In trauma situations, pressure is often brought to bear on the families of those in such states to opt for the NHBD organ donation before the diagnosis of brain death is made, claiming that their loved one will be in a “vegetative state” if he or she even survives. Misdiagnosis is a real issue and one of the considerations for objection to using criteria other than brain death. Again, the cost factor of caring for this individual until such time as a more accurate diagnosis and prognosis can be made fuels the rush to opt for the more lucrative organ donation.

While disclaiming it as an argument for the criteria of brain death, I would point to an argument against the non-heartbeating criteria of death in which the NewScientist points out that harvesting organs only after brain death draws a clear line in the sand. It removes any conflict between patient care and the interests of organ recipients because too often, the decision to withdraw life support is a subjective one (Nowak.& Geddes 2006).

Regarding the waiting time, the article reports that “transplant surgeons who perform DCD (NHBD) point to a key safeguard in their protocols - a waiting period between cessation of heartbeat and allowing the transplant team to go to work. However, even this is being eroded by the need to retrieve organs before they become too damaged. Originally a 10-minute waiting period was chosen because after this time the patient *would likely be brain-dead too*. In many

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transplant centres this has now dropped to 5 minutes, while three US transplant centers use a 2-minute interval” (Nowak & Geddes 2006).

In uncontrolled NHBD, the preservation procedure is problematic without consent and is legal in only a few states at this time. Regarding consent, Baruch points out that the Regional organ Bank of Illinois, after being refused permission for cannulation in 35 cases, undertook preservative infusion without family consent. There are also technical difficulties, a cost factor, and public resistance. All of these obstacles can and probably will be surmounted in the future given the demand for organs. In the controlled NHBD situation, the use of the drugs employed (Heparin and Regitine) in order to preserve the organs have been implicated as contributing to the death of the patient as opposed to the actual condition being the cause of death.

In the consideration of treatment administered, why the recommendation for anesthesia for the donor be considered if the patient is truly dead? Tarsitano reports that Anesthesiologist Philip Keep told the BBC that “nurses get really upset when you stick a knife in (the donor whose organs are being removed) and the blood pressure and pulse shoot up.” Therefore, many hospitals recommend administration of anesthesia prior to harvest. Dr. Keep also notes “If you do not do anything at all, the patient will start moving and wriggling around and it’s impossible to do the operation.” Whether or not this is a response of a still functioning autonomic nervous system in the body of a deceased person is not the issue. It is rather uncivilized and just the knowledge that this would be the case had the anesthetic not been employed should be enough to make the most insensitive of us just a little squeamish about the procedure (Tarsitano 2003).

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Other ethical considerations pointed out by Baruch in considering NHBD are respect issues of the persons or bodies, compromise of trust in medical profession, religious objections, use of organ preserving drugs that may shorten the life of the dying donor, and the role of the doctrine of double effect in the use of organ preserving drugs.

In both the case of brain death and cardiopulmonary criteria, there are those who consider either of them too restrictive. In the previously cited argument against brain death criteria, although Truog and Robinson agree with Baruch that it fails to correlate with any biological or philosophical understanding of death, they find it hampers the harvesting of organs. They maintain that “individuals who desire to donate their organs and who are either neurologically devastated or imminently dying should be allowed to donate their organs *without first being declared dead*” (Truog & Robinson 2003).

An overriding consideration of how to perceive individuals of compromised physical and/or cognitive faculties is to determine who it is who will sit in judgment of who is to be considered dead and therefore a candidate for organ harvesting and who is not. While families are generally thought of as having the best interest of the patient as their goal, there are numerous instances where financial considerations influence the decisions made as they watch while large sums of money are being used to care for a family member. Although the Pittsburgh Protocols address to some degree the conflict of interest on the part of the medical personnel, they do not address, and probably cannot assess, the motives of family members. As Pearl S. Buck said “I fear the choice over life or death at human hands. I see no human being whom I could ever trust with such power -- not myself nor any other. Human wisdom and human integrity are not great enough.”

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Objection to certain organ procurement protocols, indeed, even organ procurement in general, comes from unusual sources. In a 2003 article in Touchstone Magazine “Parting With Our Bodies”, Louis R. Tarsitano reports that even Playboy Magazine has issues with current criteria for organ harvesting. The article in October 2003’s magazine reports that the mortality rate due to injury among men 18 to 35 is about twice that of the national average. Author Steve Salerno claims that organ procurement organizations are “waiting for you to do something stupid.” Tarsitano, who served as a hospital chaplain for some period of time, makes some very appropriate personal observations about patients and the hospital environment and declares that “Hard cases make bad laws. And death is the ultimate hard case” (Tarsitano 2003)

Personhood Argument and Death of the Soul

In response to Baruch’s question of whether death of the brain equates to the death of the organism, we have the personhood argument to consider. Some, if not many, philosophers argue that a human being is indeed a human being only if the requirements of personhood are met.

Personhood is a much debated term and carries with it various criteria depending on who is defining the term. Criteria include variations on the characteristics of consciousness, memory, language (communication), autonomy, reasoning, self motivated activity, self awareness, and, sometimes, moral responsibility. Since end of life issues closely parallel the beginning of life issues, many of the same criteria are applied to determine who is alive and who is dead.

With regard to the beginning stages of life, it is becoming an increasingly accepted position from a biologic perspective that a new human being comes into existence when fertilization occurs. It has been argued that personhood is conferred with this status. Attempts to

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place conferrence of humanity at any other stage are seriously problematic, but there are those who insist on trying to do so.

D. Gareth Jones points out that if we become persons at the time of conception, “neurobiology is irrelevant...similarly at the end of life, a neurobiologist can provide nothing of substance if the only acceptable criterion for death is cessation of respiration.. But if

neurobiology is irrelevant, the urgent bioethical quandaries at the beginning and the end of human life will have to be addressed solely on the grounds other than scientific ones” (Jeeves 2004).

But there remain those who argue that we only become persons when we are capable of meeting the criteria of personhood. By much of this criteria, newborns are not human beings and, therefore, not to be afforded the same consideration both legally and socially as those possessing these characteristics. Peter Singer of Princeton has notoriously declared that young pigs have more sentience than a newborn and therefore have more status and worth.

At whatever stage scientists and ethicists decide that personhood should be conferred, we then need to determine when this status is to be removed, i.e., when is this person is dead and the personhood status removed. Christian ethicists need to be involved in the conversations that lead to this decision, but that is a separate issue from the considerations of this paper.

One pertinent aspect of this consideration, however, is to examine the concept of dualism with regard to human nature. Whether we are ensouled bodies or embodied souls has been a subject of theological and philosophical debate for centuries. In either case, is it necessary to make a determination of when the two are no longer unified to make a declaration of death?

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Recent research adds a new dimension to consider. What if, as Diogenes Allen considers may be possible, further research determines that all cognitive faculties are simply the result of well defined neurological pathways that can be explained in scientific terms? (Jeeves 2004). Will this signal the end of considerations of a *soul* for the human being? Will we then be regarded as having only a physical nature and the spiritual nature be something our neurological pathways determine? At this time, there is no way to determine where such research will lead or what will be the outcome for the consideration of personhood, but it is another area to watch closely.

Warren Brown claims that “Research in neuroscience raises the possibility that the concept of a separate, immaterial soul is unnecessary with respect to understanding human life and experience.” He proposes “nonreductive physicalism” as a solution to the problem of maintaining a strong sense of human personhood and soulshenness without recourse to dualism which now permeates the thinking. His argument that “Humans become persons with particular value in the cosmos not by the presence of unique additional substance (an immortal soul), but by a unique relationship to God.” But this does not lead to a conclusion as to when a person can be declared dead for the purpose of removing his or her organs. It is also not a valid point with those who do not believe in God or who continue to ascribe to the Cartesian or dualistic nature to man. It offers a new perspective only to those who believe in a God who has a role in our being.

There is nothing science has been able to offer to explain certain paranormal experiences such as near death experiences (NDE) in which a person who is clinically dead and resuscitated has been revived and recounts out of body experiences in which that person observed what transpired during the time he or she was “dead”. In an August 2003 Readers Digest article, Anita

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Bartholomew relates the neurosurgery of a woman who was told that during the time of the operation, her heart would stop beating and her brain function would cease. By all clinical measures, she would be dead for up to an hour. "...even though her eyes and ears were effectively sealed shut, she perceived what was actually happening. ...(the surgeon) gave the order to bring Reynolds to "standstill"... By every reading of every instrument, life left her body. ...she found herself traveling down a tunnel toward a light. At its end, she saw her long-dead grandmother, relatives and friends. Then an uncle led her back to her body and instructed her to return." Her surgeons told her that she had "no brain activity at all".

Bartholomew examines the phenomenon of NDE and finds great controversy over this experience, but that those who deny it have no explanation for how it could occur if there is no brain activity. "While most medical researchers wouldn't be caught dead uttering the word soul, some find the idea that NDE's are triggered by the failing brain to be inadequate. They speculate that NDE's may be evidence, not of an afterlife, but of something just as stunning; Consciousness does not reside solely in the brain" (Bartholomew 2003).

One study cited by Bartholomew reports that of 343 survivors of cardiac arrest, eighteen percent "have a story of very clear consciousness." Two researchers interviewed by Bartholomew believe their findings suggest consciousness could exist in the absence of a functioning brain and that consciousness exists in every cell of the body. Bartholomew concludes:

"That hypothesis may lead us away from the interpretation of NDE's as evidence of an afterlife. But it opens up fascinating horizons and a Pandora's Box of its own. What does it mean if the mind persists after the brain is dead? Should we, for instance, rethink the harvesting

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of organs for transplant from the “brain-dead”? The NDE may force us to re-examine questions we thought we had answers to: What is death? Where is consciousness? And can science find the soul?”

In his Letter to the Pontifical Academy in January of 2005, John Paul observes that from the Christian perspective, “the moment of death for each person consists in the definitive loss of the constitutive unity of body and spirit.” conceding that it does not provide an adequate response to medical questions about brain death. And it does not address or suggest how to make the determination of when this unity ceases and it becomes ethical to remove life sustaining organs.

The problem which exists in using most of these arguments and analyses such as these proposed by contributors to Malcolm Jeeves otherwise marvelous compilation of papers regarding considerations of personhood, is the milieu in which they are presented. When we attempt to present these arguments to the larger scientific community, many do not accept the existence of God, or not, at least, to any role a Supreme Being plays in determining how we are to think about science. We find ourselves involved in the Creationism v. Intelligent Design debate which will remain unsettled for many years to come. Meanwhile, we have the concern about criteria of death for the purpose of organ procurement which we face immediately.

As Christians, we are forced to address the considerations about when life begins and ends in terms that are acceptable to the larger scientific community who do not share our views on the dignity of man as created in the image and likeness of God. We find ourselves dealing in terms we are not comfortable with, terms which dehumanize the person and color our perception of the human being. William Brennan has devoted an entire text to the consideration of how the

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terms we use affect how we think about abortion and we find the same principles apply in dealing with end of life issues (Brennan 2000). We find ourselves talking about “brain death” when the concept is still debated among ethicists, “vegetative” states as if humans could be compared to a vegetable, and “futile care” as if care of another human being is ever futile.

We find the necessity of resorting to purely scientific arguments regarding the rejection of current criteria for organ donation. It is not all a bad thing. There are still many valid arguments for the rejection of criteria for death that do not call on a belief in any Supernatural Being as Author of Code of Conduct, many already enumerated in this paper.

But subjective unscientific considerations continue to invade the debate. This is precisely the rationale behind the Supreme Court Justice Anthony Kennedy’s “mystery of life” speech in *Planned Parenthood v. Casey*: “At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State” (Kennedy in *Planned Parenthood v. Casey* 1992).

When each of us has a right to define his concept of existence, what prevents those in power from defining personhood to their own benefit? What about those “experts” and ethicists who allow for the killing of those who fail to meet personhood criteria established by them? Gilbert Meilander describes it as the circle of personhood becoming ever smaller while those elitists who make the decisions are at the center of the circle, safe from the decrees of others. It is a luxury not afforded to every man.

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We wonder why it is that the life of the person who is on a waiting list for organ donation is more valuable than the life of the donor who may be being asked to sacrifice his life for his organs. Have we as human beings come to the place where we are more valuable for our parts than for the inherent value of who we are? Even the secularists have reservations about what this attitude means for us as a society. Certainly as Christians it gives us pause to consider that we are no longer viewed as having inherent worth having been created in the image and likeness of God.

Conclusion:

While the arguments for the current criteria of death for the purpose of organ harvesting are made to sound beneficial and noble, a look at the blatant abuses of the loose criteria which now exist should make us reluctant to give any of us the ability to make these life or death decisions over one another.

The pressure for organ donation for transplants has created a lowering of criteria for declaration of death to that which is not compatible with the respect for the life of the donor and therefore, not ethical. Compliance with more rigorous criteria to assure that death has, indeed, occurred, would undoubtedly result in fewer viable organs for transplant. But in ascribing to an ethic which is consistent with a respect for all living persons, it is a consequence we need to seriously consider. Alan J. Torrence notes that in 1738, David Hume's *Treatise on Human Nature* opined that his paper was not as much a conclusion as a challenge: (Jeeves 2004)

It is not happy to end a book with a dilemma, but we should all take it as a challenge, a challenge to find an account of mentality that respects consciousness as a genuine phenomenon

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that gives us and other sentient beings a special place in the world and that also makes consciousness a causally efficacious factor in the workings of the natural world. The challenge, then, is to find out what kind of beings we are and what our place is in the world of nature.

We have a challenge to consider the criteria of death for the purpose of harvesting organs from an ethical perspective. Indeed, we do live in a society which values scientific progress over any ethical concerns. As Christians, we face a difficult challenge.

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