

## Organ Transplantation and the Dead Donor Rule – SCBI August 2008

Organ donation has been widely promoted as a powerful expression of altruism and as a gift of life. Organs like kidneys as well as sections of lung and liver can be removed from living donors, but vital organs like the heart cannot - for obvious reasons. The most common occurrence is that individuals consent to organs being removed after death, or if they are not able to consent, their next of kin may do so. But the crucial point is that it must occur after death. This is called the 'dead donor rule', and most ethicists as well as medical professionals agree. For to remove vital organs from patients who are not dead, or for whom there is uncertainty about whether they are dead, is to bring about their death by removing their vital organs. That is to kill them.

In a recent paper in the *New England Journal of Medicine*, heart transplant surgeons described how they modified the definition of death for three brain-damaged infants whose hearts were removed for transplantation into three other infants with severe heart problems. The controversy surrounds the likelihood that the children were not in fact dead.

The journal invited two bioethicists, Robert Truog and Franklin Miller, to write a commentary, which is when the controversy really began to deepen. The essential line taken by Truog and Miller is that it really doesn't matter whether the patient is dead or not. Instead what really counts is whether informed consent has been given. In their assertion that it is "perfectly ethical" to remove organs from patients who are *not really* or *convincingly* dead, they give voice to the utilitarian ethic, which is that the outcome – organs that save people's lives - is really so good that traditionally unethical means can be justified.

There are two ways in which death has been defined, brain death and cardiac death.

Brain death criteria were proposed in 1968 by a Harvard Medical School Committee and, though controversial, have since been established as sufficient for a declaration of death in cases of patients suffering "devastating neurological injury [and] suitable for organ transplantation under the dead donor rule". Truog and Miller think the concept of brain death has "served us well" because without it, procuring organs would not happen and so organs for transplantation would be scarce. Rather than the concept being right, they instead consider 'being served well' to be what counts.

Crucially, Truog and Miller agree with the concerns expressed by many over the years that the concept of brain death is flawed, as is the concept of cardiac death. Indeed, in the paper regarding heart transplants from brain-damaged infants, not only were the infants *not* declared brain dead, but a mere 75 seconds was allowed to pass from the heart stopping to organ removal. This is significantly less than the 2-5 minutes usually used to declare cardiac death. Instead of cardiac function having irreversibly ceased, Truog and Miller instead suggest that, "... in this context irreversibility is interpreted as the result of a choice not to reverse." In this they are correct.

For Truog and Miller to construct an argument that it doesn't really matter whether donors are dead or not, they rely on a utilitarian argument that denies a well-established principle of medical ethics – the principle of double effect. In this context, this principle says that it can be ethically sound to withdraw treatment from someone if the treatment is futile or burdensome disproportionate to benefit. So an infant can have life support withdrawn and then die from the underlying cause. The

person turning off the life support does not intend to end the child's life, but foresees that death will occur from whatever condition the child suffers from. The principle of double effect operates in the tragic reality of some end of life scenarios to nevertheless uphold the value of life itself and it never permits an intentional act to end life. But Truog and Miller instead endorse the utilitarian ethic that only consequences really matter. They would have us believe that turning off life support is what actually kills the child. This then allows them to equate removing life support with removing organs. In both cases, they argue, death follows by the hand of a medical professional. Their argument is, quite literally, deadly. They say, "whether death occurs as the result of ventilator withdrawal or organ procurement, the ethically relevant precondition is valid consent by the patient or surrogate. With such consent, there is no harm or wrong done in retrieving vital organs before death, provided that anesthesia is administered."

One of the problems with such an argument is that it not only fails to recognise the inherent dignity of the infant and his or her sanctity of life, but also ignores the virtue (or lack of it) of a physician prepared to carry out such an act. Furthermore, the likelihood that public trust will be undermined by the knowledge that vital organs will be procured from live donors doesn't rate a mention. The utilitarian calculus can be selective when it comes to "harm or wrong done".

While Truog and Miller restrict their argument to "the limited conditions of devastating neurologic injury", they provide no argument as to why. Which is disconcerting because there appears to be no sound reason why their argument could not apply far more widely. In fact pro-euthanasia advocates would no doubt be pleased to see unfettered autonomy promoted as the only really significant ethical point to make in such end of life scenarios. Could we soon see euthanasia linked to organ donation? Could the 'altruism card' of organ donation be played to add nobility to an otherwise morbid cause?

What the NEJM study and Truog and Miller's commentary does highlight is that for the dead donor rule to remain as a primary principle in the ethics of organ donation, some very careful thought needs to go into criteria that are acceptable for the difficult questions surrounding the determination of death?