

## **Liberty and the Dead Donor Rule**

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## **A Shark in the Donor Pool**

The history of organ donation has been marked by ethical debates and shifting attitudes about what constitutes a morally acceptable donor.<sup>1</sup> When concerns about coercion and commercialization of live organ donation arose, non-heart-beating cadaver donors (NHBCDs) came into use. As demand increased, the relatively poor results from NHBCDs prompted the notion of using neurologic criteria for death. A significant number of additional patients could be declared brain dead, and, because their hearts still beat, their organs would not be damaged by warm ischemia. In 1968, the Ad Hoc Committee of the Harvard Medical School drafted a paper outlining criteria and tests for brain death. Their stated goals were to decrease the burden on family and society of continued therapy and to update the obsolete, i.e., cardiopulmonary, criteria for death that led to controversy in harvesting organs.

Since then, the criteria for brain death outlined in the Harvard paper have become standard in many countries. The Uniform Determination of Death Act (UDDA), which allows both heart-lung and brain criteria for death, has become law in many states. Through the use of these heart-beating cadaver donors (HBCDs), the number of organs available for transplant increased dramatically. But demand continued to outpace supply. For example, while the number of kidney transplants in the United States increased by 50.1% between 1988 and 1995, it was largely due to a 74.2% increase in the number of living donor transplants and a 51.3% increase in the use of cadaver donors over the age of 50. There was only a 7.0% increase in the number of cadaver donors less than 50 years old. Despite the increase, 3,500 Americans are left to die each year while awaiting a solid organ transplant.<sup>2</sup> This has provoked heated debates over allocating resources and increasing supply, including the use of live donors, artificial organs, xenograft

(transplant from non-humans) and, most commonly, renewed use of NHBCDs.

With improved methods of preserving organs against ischemic damage, organs from NHBCDs — including the kidney, liver, lungs, pancreas and heart — are now in many cases as viable as those from HBCDs.<sup>3</sup> Indeed, the medical literature on NHBCDs is riddled with positive outcomes and statements from straightforward recommendations to the impassioned: “We therefore plead for the introduction of NHB kidney procurement protocols.”<sup>4</sup> Despite such zeal and the fact that their initial discontinuance was due only to poor survival rates, NHBCDs are now facing opposition on ethical grounds with claims that various protocols for their retrieval break some or all of the fundamental axioms of organ donation. The proposed use of other types of potential organ donors (POD) face similar objections.

One tenet of organ donation is the separation principle. Fearing a conflict of interest in which a POD might be somehow compromised by the needs of a potential organ recipient (POR), it has been generally accepted that the caregivers for the POD not also care for the POR. Except in certain emergencies when it may not be possible to follow, the separation principle is generally accepted and observed. A second axiom, however, brings clearer controversy. Consent of the patient, when possible, and the patient’s family are generally required before organ donation procedures can begin. Controversies arise because there are different systems of consent and different notions about just how far one can go without consent.

In opt-in systems, such as we have in the United States, the patient or next of kin must provide explicit consent to authorize organ donation. Opt-out systems, common in Europe, operate with presumed consent, in which physicians can proceed with organ donation procedures unless the patient is determined to be registered as a non-donor. Other possible systems include

mandated choice (in which all adults must choose whether to be an organ donor or not), conscription (in which organs are “drafted” by the state),<sup>5</sup> and even commercialization of organ acquisition and forced donation from prisoners sentenced to death. Proponents of each system claim that others are ineffective and/or unethical. In addition, the conflict between POD and POR may affect consent: families may be pressured into giving consent when they do not wish to, while, on the other hand, a doctor may not seek consent strongly enough for fear of coercion, when a family might give permission if asked.

Probably the most important axiom of organ donation is the dead donor rule, from which myriad controversies have arisen as discrete issues and in conjunction with those arising from consent. The rule itself, coined by John Robertson in 1988, has never been officially legislated but has been informally developed and generally observed since brain death criteria were first proposed. It says that a person must be dead before their organs are taken and that active killing for the purposes of organ retrieval is prohibited.

According to the Maastricht breakdown,<sup>6</sup> NHBCDs fall into four categories. Type 1 are those who are dead on arrival, i.e., brain dead without a heartbeat. Type 4 are those who are brain dead and then experience cardiac arrest. The controversies arise in the use of type 2 and type 3 NHBCDs: respectively, those for whom resuscitation is unsuccessful and those awaiting cardiac arrest. The debate exists because there is disagreement over whether or not these PODs are, in fact, cadavers. If they can be shown to be alive, harvesting their organs breaks the dead donor rule and they must simply be referred to as NHBDs: the “C” disappears from the acronym because the donor is not a cadaver. (Clearly the “equality” of heart-lung and brain criteria described in the UDDA is somewhat illusory.) Institutions around the world have developed

protocols for dealing with type 2 and type 3 NHBCDs, but these protocols come under fire as potentially breaking the dead donor rule, hastening patients' deaths and, in some cases, failing to obtain consent.

The most notorious protocol appears to be that developed by the University of Pittsburgh Medical Center. The Pittsburgh protocol deals with type 3 donors in a situation known as "controlled death." A patient on life support agrees to have support withdrawn so that organs may be harvested. The family must say their farewells before the patient is taken to an operating room. There, preparation for organ removal begins and support is withdrawn. Physicians wait until two minutes after cardiopulmonary death to begin retrieving organs. The procedure's speed preserves organs well, yielding an estimated 20-25% increase in organ availability at the medical center. Critics such as Alan J. Weisbard<sup>7</sup> and Renée C. Fox<sup>8</sup> argue that the Pittsburgh protocol breaks the dead donor rule because two minutes is insufficient time to assure brain death. They further criticize the procedure in that the preparation of the patient for organ removal before death is non-therapeutic and further because the patient's family cannot be present at the moment of death.

A controversy that can arise with type 2 NHBCDs is that, after attempts at resuscitation are deemed unsuccessful, the heart may start after the patient is "mistakenly" declared dead. Is the donor alive and therefore deserving of further care, or had the donor simply become a type 4 NHBCD, one who experienced cardiac arrest after brain death and therefore could be considered a cadaver? Different protocols for dealing with type 2 and type 3 NHBCDs have been developed by hospitals in Madrid, the Netherlands, Illinois, Washington, DC, and elsewhere, but all yield similar quandaries.

There are other categories of PODs who are not NHBCDs but who likewise cause controversies with respect to the dead donor rule. Some propose the use of anencephalic infants and adults in persistent vegetative state (PVS), claiming that, while they may not be dead, retrieving organs violates no interest and is therefore permissible.<sup>9</sup> Another type of POD was accounted for in the protocol developed by the Royal Devon and Exeter Hospital in the United Kingdom. With family consent, the Exeter protocol allowed for patients for whom imminent brain death was predicted to receive artificial ventilation so that organs would remain preserved once brain death actually occurred. Family acceptance was high, and Exeter produced the highest rate of organ procurement of any region in the UK.<sup>10</sup> The Health Departments of England and Wales, however, declared that elective ventilation for transplantation purposes constituted unlawful battery, being both non-therapeutic and not in the best interest of the patient.<sup>11</sup> Exeter suspended the practice.

The medical community appears to be suffering from an embarrassment of riches. Developments in life support and in transplantation both help prolong and save lives, but they are often at odds with each other, pitting the rights of PODs against the needs of PORs and forcing their respective caregivers into parallel conflicts of interest. To save some lives, it appears necessary that others must be sacrificed. This irony is the shark in the donor pool, both endangering those already in the pool and keeping others from taking a swim in the first place.

The arguments for allowing these controversial procedures mirror those in favor of organ donation in general. There is a need, the procedures are effective, people should be altruistic and, in cases such as kidney failure, organ donation can be the cheapest option. Further, donation may help a family make sense of the tragic loss of a loved one. Indeed, 89% of families who allowed

organ donation say they would do so again.<sup>12</sup> The objections, however, are compelling. The public may lose trust in the transplant community (which may ironically lead to an overall reduced rate of organ donation), the line between life and death may become blurred, and additional stress may be placed on patients, their families and the health care providers involved. Beyond all of this is the notion that a utilitarian approach to the issue is simply cold and inappropriate.

In the final paper of the *Kennedy Institute of Ethics Journal's* special issue on NHBCDs, Robert M. Arnold and Stuart J. Youngner eloquently express concern about organs being taken from patients who are “probably dead, practically dead, as good as dead, almost dead, but not *certainly dead* patients.”<sup>13</sup> They suggest that, since these controversies make the line between life and death both conceptually and morally dim, we should consider abandoning the dead donor rule rather than tamper with it. They say “...why not simply go along with the quieter strategy of policy creep? It seems to be getting us where we seem to want to go,” offering instead that we rely completely on a rigorous system of informed consent as a safeguard against abuse.

Developing a rigorous consent process is certainly advisable, but I do not believe that the dead donor rule should be abandoned en route. The only alternative to the rule is murder, no matter what the “exotic justificatory techniques.”<sup>14</sup> These controversies hinge upon whether or not certain PODs fulfill criteria for death, whether heart-lung or brain. Clearly such definitions have proved unhelpful by contributing to rather than resolving the debate. Indeed, since brain death was initially proposed as a measure to increase the donor pool, the public and the medical community are rightfully suspicious when suggestions are made to increase the pool again by toying with the dead donor rule. Perhaps a closer look at defining death may lead to an alternative.

## **How Do You Pronounce Death?**

A primary question about death is whether it is a process or an event. Charles M. Culver and Bernard Gert provide an excellent argument for why death should be identified as the specific “event which separates the process of dying from the process of disintegration”<sup>15</sup> as opposed to a process. Even those who believe it to be a process must identify a time after which a person can be considered dead.<sup>16</sup> Dying is the process and death is its result. I will therefore take biological death to be an event. The question of when it takes place remains.

Culver and Gert define death as “the permanent cessation of the functioning of the organism as a whole.”<sup>17</sup> It should be noted, though, that the organism as a whole is not the same as the whole organism. Cessation of the function of the whole organism occurs only when every cell in the body has died, usually through autolysis and necrosis and long after the body has putrefied.<sup>18</sup> At any time prior to this, however, no matter how technical or petty the arguments may be, controversy may arise. The ancient Thracians, Greeks and Romans waited at least three days for putrefaction to begin before burying or cremating their dead.<sup>19</sup> Few would dispute that death has occurred once putrefaction has set in, but for the purposes of this discussion, I will for the moment forsake Culver and Gert’s placement of the event of death, labeling only the moment when the body’s last living cell dies as the moment of complete biological death (MCBD).

It would, of course, be impractical to use the MCBD as our only definition of death. It may take centuries to reach this moment and it is essentially impossible to know when the last living cell died, not to mention the unpleasantness that would arise from putting off disposal of remains. Literature on the subject is universal in claiming that death occurs before this point. Indisputable as the MCBD may be, society inevitably has great interest in labeling a person dead

before it is reached. But if this is the point after which almost none would disagree that a person is dead, we can only begin to zero in on a socially acceptable moment prior to that moment by first finding the point before which almost none would disagree that a person is alive. Is it, in fact, the moment of heart-lung death or brain death?

Consider two extreme examples. First, a person is decapitated. The heart may beat and the brain may display electrical activity, possibly for several seconds after the head is separated from the torso. A second person stands next to a powerful bomb at the moment of detonation. Within seconds, no piece of the person larger than a grape is left. We may be able to retrieve parts of the brain which display, if momentarily, electrical activity. These two people have not yet reached the M CBD, but it is nevertheless doubtful that anybody would bother to invoke heart-lung or brain criteria to claim that they are still alive. What is certain, though, is that both have reached the permanent cessation of the functioning of the organism as a whole. How should we proceed from here to find an acceptable definition? Perhaps we can find, in addition to the M CBD, other markers more grounded in time and less attached to specific physiological phenomena than heart-lung death or brain death.

At the risk of sounding essentialist, consciousness is a hallmark of personhood. Some may consider humans in various levels of unconsciousness to be alive, but surely the goal of all heroic medicine — transplantation, resuscitative methods, etc. — is to return a patient to consciousness. If unconsciousness is the only result achieved, even doctors and family members who consider the patient to be alive would surely be disappointed with the results. The patient may not be dead, but the efforts would be seen as a failure. All other bodily systems may function, but a human who has irreversibly lost consciousness may be said to have reached the end of personhood and

thus the permanent cessation of the functioning of the organism as a whole.

A person diagnosed with incurable cancer has passed a certain point of no return with respect to the dying process, but then so has any person who has simply been born, since all will die. The moment that a person becomes irreversibly unconscious is the point of no return crucial to this discussion. This biological time marker, however, can be modified by the decision to intervene medically, a social factor to be sure but one which has great bearing on the biology of death. Since medical intervention may succeed in bringing a patient “back to life” when leaving the person alone might not, it effectively creates an alternate point of no return. The cancer patient is certainly not dead simply by virtue of having been diagnosed with a terminal illness.

Thus, we can identify two more key points during the dying process, points of no return to consciousness. A typical person might pass the point of no return without medical intervention (PNR-W/O), then the point of no return with medical intervention (PNR-W), then through some series of physiological events reach the MCBBD. Note, though, that while the MCBBD cannot come before the PNR-W, they can be simultaneous. Likewise, while the PNR-W cannot come before the PNR-W/O, they too can be simultaneous. Consider also that a person may be said to be *dying* even before passing the PNR-W/O, as in the case of the conscious cancer victim. The passing of the PNR-W/O and the PNR-W indicate that a person has entered the final stages of the dying process, however long that may be for a given case. But note that medication intervention may not only prolong the dying process, it may stop it: a person goes unconscious due to a brain aneurism which is then surgically removed. The patient had passed the PNR-W/O, but was brought out of the dying process, possibly to live for decades more.

How do these three temporal markers of the final stages of dying relate to the loss of

heartbeat and of brain function? These physiological phenomena clearly must occur before or, in rare cases, simultaneously with the M CBD, so the issue that remains is their relation to the points of no return. In relatively common situations, heart-lung death and brain death do not have a strict temporal relationship. Either may precede the other, depending on the circumstances. Thus no concrete conclusion can be drawn about temporal order for those phenomena in and of themselves.

Let us return to the extreme examples from before. Both the decapitated person and the explosion victim have surely passed the two PNRs, unless medicine should one day figure out how to reattach a severed head, in which case that person would have passed only the PNR-W/O. Consider two additional examples: A person is flash frozen at absolute zero, straight through to the bone. For such a person, heart stoppage, loss of all brain function, the PNR-W/O, the PNR-W and the M CBD are all reached simultaneously. Another person's heart stops while he is conscious. Only moments later does lack of circulation to the brain cause unconsciousness and later death.

It is clear that these physiological phenomena are not fundamentally related to the two points. In the end, the only certain relationship we can show between the physiological criteria for death and the three temporal markers is that they can only occur as early as just prior to the PNR-W/O and cannot occur after the M CBD. Between these extremes, almost any sequence of events seems possible, if unlikely. Thus, neither loss of heartbeat, loss of brain function nor any other physiological phenomenon that can identify a PNR will suffice as an absolute definition of death. Only the true M CBD fulfills this purpose.

This is not to say that other definitions should not be used, since the M CBD is indeed

impractical for social convention. The crux is that, short of the M CBD, death is always a social convention, something agreed upon. No matter how based in objective science they may be, all definitions of death must be recognized, biologically speaking, simply as different degrees of “as good as dead” which are acceptable to different people based on their unique values. These values lead to judgments of death which can only be considered metaphysical, and all that varies is the basis for the metaphysics, which can just as likely be religion or philosophy as it can be science and medicine.

Consider how the United States contrasts with Japan. In both countries, “efforts are made to assign the concepts of life and death to scientifically deducible and verifiable categories, and thus to make them indisputable beyond professional medical circles... ‘Beliefs’ and ‘values’ are, of course, acknowledged, but supposedly set aside in the daily round of medical decision making and practice.”<sup>20</sup> Nevertheless, the general opinion in Japan is that there is no specific, scientifically definable moment of death and, if there is, brain criteria are unacceptable in determining it. This contrasts greatly with the United States, where the moment of death is, for the most part, deemed unquestionably to exist, with opinion varying only around its timing and much current agreement about brain death criteria being involved. Indeed, how one pronounces death may be very different depending on what language is spoken, and even within the same language death may vary with dialect.

### **Give Me Liberty *and* Give Me Death**

The new question, then, is: which social definition of death are we to use? To answer this, perhaps we should first define the range of possibilities. It appeared that just prior to the PNR-

W/O is the earliest acceptable social definition of death and the M CBD is the latest. Setting the range in this manner, of course, can cause controversy. Should we use heart-lung or brain criteria? What about a person in PVS, who has passed both PNRs and yet can be argued to remain alive?

Or have we not even properly defined the limits of the range? For example, Jewish tradition holds that the parents of a child who marries out of the faith are to mourn the loss of the child as dead. Under these circumstances, however, it is exceedingly unlikely that anyone, including the offended parents, would justify physical harm toward the child on the grounds of a loss of personhood. Is this a true definition of death in which physiology does not enter into the picture at all, with death being declared for purely social reasons before even the PNR-W/O is reached, or is this merely an act of symbolism? And what about the ancient Thracians, Romans and Greeks who waited until long after heart-lung and brain criteria had clearly been fulfilled? These examples seem to permit death before and after the range previously specified. Shall we now say that the moment of social death can be declared at any time at all? Shall we impose a rule that persons declared dead for purely social reasons should not be physically harmed, or is it conceivable that a society might justify physically tormenting, even to physiological death, their purely-socially-dead — humans who are alive and fully conscious — on the grounds that they have, in fact, lost personhood? Would this not be a convenient way to justify capital punishment without raising the specter of murder? With the range of possibilities expanded *ad absurdum*, the question of which definition to use now seems to be impossible to answer.

The impossibility, however, arises only when one approaches the question as if there must be one right answer that should apply for all, and that is not at all the case. As Helga Kuhse says,

“Different moral perspectives, or value systems, will give rise to different answers — and these answers cannot be shown to be true or false, in the ordinary sense of those terms.”<sup>21</sup> Because death is always at least in part a social construction, it can only be determined by criteria and tests deemed relevant, medically or otherwise, to a given person or persons. That people may live in a society whose majority opinion is different is incidental. Things change and different ideas come to fore. Differences in values must be permitted, for if the majority forbids views other than their own, they may one day find their own views forbidden when different values dominate the society. Because nobody can be proved right or wrong in matters of ethics and metaphysics, tolerance must be practiced. People do not have to understand or even like each other, but they must at the base level tolerate each other’s existence and respect each other’s liberty, lest they endanger their own.

Liberty arguments, so common in the literature on euthanasia and assisted suicide, must therefore also be applied to the definition of death itself. We must be free to live how we want as long as it does not keep others from living how they want. The freedom to die as one chooses, and likewise to choose one’s own definition of death, follows. How we live or die may harm the sensibilities of others without impinging on their liberty. Medical intervention goes against some people’s values. Declaring a person in PVS to be dead goes against others. Those who disagree must respect the choices of others, even if they do not condone those views.

What, then, should we do about people who justify “murdering” the socially dead? Surely most societies would think this horrific, but it would not be the first time that some people felt this way about others. Nobody should have the right to prohibit the behavior of someone else unless it impinges on their own cultural liberty. We may try to convince others of our own way of

thinking, but if they decide to join us it should be of their own choice, not through coercion.

The liberty of an individual with a minority view, however, must clearly not be granted at the expense of the majority. With respect to legislating definitions of death, a majority must be allowed to accept a default definition for its jurisdiction. In the absence of proof of a different choice, the default must hold sway for all patients. If a society wants to express ultimate liberty, the default definition will be conservative, i.e., a “late” definition, one that places death as far along as possible, and that society will accept a loss of PODs as the price they pay for liberty in life. A society that wants to increase the donor pool as much as possible will pick the most liberal, i.e., “early” definition, and the possibility of such a death is the price one pays for the comfort of knowing that a large donor pool exists. It is ironic but not paradoxical that what might be construed as the most liberal society picks the most conservative definition of death and vice versa.

Will it be difficult to implement such variation? Not as much as it seems. We all tacitly understand that we must follow the laws for whatever jurisdiction we find ourselves in. In New York City, if you turn right at a red light you get a ticket. If you commit vandalism in Singapore, you get a caning. In Turkey, if you conceal marijuana you get thrown into a (Turkish!) prison. It is the responsibility of each resident and visitor to know and obey all pertinent laws and to pay the penalty for breaking them. Anyone who is unwilling to submit to such rules should simply choose somewhere else to reside or visit. The buyer is not the only one who must beware. And though varying definitions of death will certainly lead to questions about issues ranging from health and life insurance to governmental processes, these complications will simply supplant existing ones and will do so in the name of upholding liberty.

The very idea of a Uniform Determination of Death Act is misguided if it intends to be a statement of the correct definition of death. It's not that brain death is the wrong answer, it's just not the right answer for everyone, e.g., the Japanese. A uniform definition of death depends upon a uniform consensus over what constitutes "personhood,"<sup>22</sup> and there is no such consensus, at least not on a national level. If the UDDA can be taken simply as a majority default opinion that can be modified by local variation through the use of a conscience clause like the one Robert M. Veatch proposes,<sup>23</sup> it is perfectly acceptable and even advisable. Indeed, New Jersey allows individuals to choose heart-lung over brain criteria<sup>24</sup> while Arizona permits withdrawal of life support from persons in PVS.<sup>25</sup> Even do-not-resuscitate orders provide a way in which people may, in effect, choose their own definition of death. I would go even farther, proposing that defining death be encouraged on all jurisdictional levels. Each level, whether state, county or town, would have the freedom to override the default definition of the level above with its own, straight down to the individual whose chosen definition could differ from the default for wherever he may find himself.

We must allow the "earliest" definitions of death in order to protect the ones who want the "later" definitions. Only liberty accommodates both by providing the proper framework in which to inquire about the definition of death. In the end, the question of which definition to use becomes one that can and should only be answered by each individual.

### **To Donate or Not To Donate**

People are already granted the liberty to choose whether or not to donate organs, but the persistent paucity of organs puts the focus of transplantation on the recipient. The language must

be clarified. While transplantation is about the entire enterprise, receiving organs is about the recipient and can only occur if an organ is available. Donating organs is about the donor. If equal liberty were granted to the donor in choosing a definition of death, the issue would not be one of what is right for doctors to do regarding transplantation but simply one of the desire of the donor and her family with respect to both donation and defining death. A physician would first assess the individual's death definition choice, proceeding to next of kin if necessary, then yielding to the default set down for the given locality only as a last resort. Only then would the doctor need to consider whether or not the individual wanted to donate organs.

Would any particular system of organ donation be especially conducive to this arrangement? Mandated choice is certainly the strongest system, forcing each individual to specifically express a personal choice. Next to this, opt-in seems to be safer than opt-out. Nevertheless, any system should work out fine as long as liberty is preserved within. As with the definition of death, it would be up to everyone to know the local rules of organ donation and to understand how they are best able to exercise their liberty.

The dead donor rule could thus be preserved, and controversies such as the confusion between NHBD and NHBCD would disappear. All donors would be cadaver donors, and the acronym prefix that preceded the "CD" would simply identify any of the various definitions of deaths people choose. This would remain important for medical purposes, since organs will vary in viability based on the circumstances of death. From an ethical standpoint, though, the NHBCD, the brain dead cadaver donor (BDCD or HBCD) and the socially-dead-then-injured-until-biologically-dead cadaver donor (SDTIUBDCD!) would be indistinguishable, at least in terms of validity for donation if not in terms of agreement with the chosen definition of death.

While discussion about NHBCDs' right to life is absolutely crucial, equally important is their right to die and to donate, if that is what they desire. The very act of donation becomes contingent upon the right to die and to define one's death. A POD must be granted the liberty to declare that, as far as she is concerned, it is acceptable for a doctor to procure organs under circumstances she defines as death, even when that definition may be considered "still living" to another. It is no more a paradox to say that a person is dead by one set of criteria and alive by another than to say that a person has sinned according to one religion but not according to another.

The only possible justification for breaking the dead donor rule would be further expression of liberty in which a donor chooses to have the rule broken, for example, by permitting euthanasia or by permitting organ retrieval prior to reaching his own definition of death. Indeed, we allow and even applaud people who given up their lives for others in certain situations. Of course, a doctor has no obligation to kill you in the process of your martyrdom. If she does not agree with your chosen definition of death or course of action, you may have to find another doctor. The key is that under no circumstances could a doctor be allowed to kill or to consider someone "as good as dead." It must always be the patient's choice, and institutions would have to develop protocols to assure that doctors use only the chosen definition of death for each patient.

Points of no return and physiological phenomena are real, but diagnosing them properly is a different story. False diagnoses have occurred throughout history, but in the past it was common for people to specify in their wills various tests to confirm their death. These "tests" included stabbing the heart, extracting the heart and severing the head.<sup>26</sup> There is, then, precedent

for allowing variation in criteria for death. Indeed, some people preferred to accept the possibility of being murdered rather than argue over a set definition of death. Even in our world of modern technology and uniform definitions of death, it is still difficult for physicians to determine whether or not a patient will come out of a deep coma.

Under a liberty-driven system, doctors would have greater knowledge requirements to allow them to diagnose different types of death, and false diagnoses would be sure to continue. But while a physician or neurologist may not have any better metaphysical idea of what death is compared to a lay person, they will continue to have the best information on which to judge physiological irreversibility. People who choose medically verifiable definitions of death will have to continue to trust doctors to use their best judgment. The old adage “a person is dead when a physician says so” can remain true but will have to allow different bases for the saying so. And, like today, should a false positive diagnosis be made and a patient somehow return to life, nobody should have a problem rescinding a pronouncement of death.

The connection between the choices of donating organs and defining death does not, of course, stop at the common element of liberty. While they are indeed separate choices, they are intimately related in that the organ viability varies based on the definition of death. A donor may choose a definition incompatible with donating some or all organs and yet may choose to donate. It is up to the medical community to continue finding ways to utilize organs under extreme conditions. Alternately, another person may choose a definition completely compatible with organ donation and yet may choose not to donate. This choice must be respected.

It should be noted that altruism with respect to organ donation is not the only reason a person may choose an “early” definition of death. People may have strong beliefs against medical

intervention, grounded in religion or nature, or beliefs about allocation of resources, both in terms of medical treatment and organs themselves. The desire to reduce emotional and financial strain on family is also an important consideration for some people. In all of these cases, a donor may or may not choose to donate organs. These are all problems the doctors must deal with as well as they can. Instead of protocols which work in the gray area between life and death or right and wrong, every hospital would have a set of protocols for dealing with each type of death.

Despite the extra work involved, however, the liberty-driven system actually provides great benefits to the medical community as well as the donor. As long as people's choices are respected, the onus will be off medical staff who might otherwise have been accused of breaking the dead donor rule. The conflict of interest between PODs and PORs would disappear, and there would be no such thing as a donor sacrificed for a recipient. The parallel conflict between the caregivers of PODs and PORs would likewise vanish. Ideally, even the separation principle should be able to be eliminated, though it should be maintained whenever there is doubt. Potential conflicts between doctor and family will persist, but it would be up to the doctor to work properly within the framework of liberty to eliminate undue pressure and reduce these conflicts as much as possible.

## **Conclusions**

Attempts at universal definitions of death have resulted in ethical conflicts precisely because it is unethical, or at least inherently controversial, to impose a universal definition of death. Doing so presumes the rightness of one definition over all others when the issue at hand is intrinsically metaphysical and therefore bound to yield moral variation. The one right answer is

that there is no one right answer. While a liberty-driven attitude toward the definition of death will also impact issues such as killing versus letting die, assisted suicide, euthanasia, infanticide and abortion, it is of paramount importance to resolving the controversies that arise in attempting to expand the organ donation pool by playing with the dead donor rule.

By creating a system which permits varied definitions of death and assures that such variation is not abused, a person can be certain to be declared a cadaver only through criteria that he deems acceptable. If a person is also willing to donate organs, he can be likewise assured that there will be no ambiguity about whether or not he is a cadaver donor. By definition, this must be the case. The dead donor rule can be properly preserved while at the same time the multiple controversies surrounding it can be eliminated. The slippery slope toward “unacceptable” definitions of death becomes a level playing field in which multiple definitions can be acceptable.

Arnold and Youngner claim that the definition of death is one of the issues that “cry out for national standards,”<sup>27</sup> claiming that we should not want criteria for death to depend on geographic or institutional setting. They overlook the fact that, short of imposing global law, it already does vary geographically and that imposing a single rule is impractical on a national level precisely because of the diversity of belief within an area so large. Some issues, such as access to abortion, also vary with institutional setting. They then say, “In the long run, it is much better for the transplant community to develop comprehensive NHBCD policies with community support, even if this means not procuring as many organs in the long run.” Clearly their intentions are to do the right thing, and they recognize that the right thing is not necessarily the one with the most utility. But when they suggest that we abandon the rule rather than tamper with it, they fail to see that there is a third alternative. We can, as they say, get where we seem to want to go by leaving

the rule in place. A framework of liberty and tolerance is the key. Indeed, the dead donor rule itself follows directly from liberty and the right to life which it implies.

Likewise, however, liberty implies the right to die as one wishes. Whether the issue is life, death, donation or otherwise, we must respect each person's "right to make momentous personal decisions which invoke fundamental religious or philosophical convictions about life's value for himself."<sup>28</sup> People must be allowed to choose a definition of death that they find acceptable, preserving their liberty in the face of a potentially disagreeing majority opinion. At the same time, there is certainly something to be said for majority opinion, which must be granted liberty in its own right as well. Therefore, jurisdictional variation in defining death must be permitted, granting that such legislated definitions always be viewed as a default to use when the beliefs of a patient or next of kin are unknown. Following Veatch's example of a conscience clause, both majority and minority beliefs are preserved.

Some may object that my argument plays with the definition of death in the same way as schemes such as the Pittsburgh protocol. Those protocols, however, are specifically developed out of utilitarian motivations to increase the organ donor pool. The point of my argument is precisely to avoid this. Rather than place the definition of death in the hands of those who would use a corpse for some benefit, the liberty framework places it where it always should have been: in the hands of the individual who may express her own values, whatever they may be, regardless of how they affect the donor pool. In this manner, the rule itself becomes immune to changing technology and thus to constant utilitarian redefinition of death, which could be justified whenever utility required it. Liberty prevents unwanted persons from being defined out of existence.<sup>29</sup> Utilitarianism does not justify use of NHBCDs. Liberty justifies both either use or non-use.

Will the liberty framework increase the organ supply? Who knows. But because cadavers provide the largest supply of organs today, it is crucial that they be handled in the most appropriate manner possible. As proficiency in organ transplantation grows it will be indicated in more cases, including the more aged and the more ill, and demand will continue to increase. Probably no solution for meeting that demand will be free of ethical problems, and indeed some methods will pose great dilemmas, just as cadaver donation does today. Regardless of how a liberty framework affects the donor supply and of what future developments may occur, there may come a time when the transplantation community will have to face the simple fact that you can't always get what you want or need. While meeting demand would be wonderful, there is no moral obligation to do so. No law or protocol can ever change that. We must content ourselves with what we can have, and what we all can and must have is freedom.

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