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Donation After Circulatory Death: Burying the Dead Donor Rule

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Despite continuing controversies regarding the vital status of both brain-dead donors and individuals who undergo donation after circulatory death (DCD), respecting the dead donor rule (DDR) remains the standard moral framework for organ procurement. The DDR increases organ supply without jeopardizing trust in transplantation systems, reassuring society that donors will not experience harm during organ procurement. While the assumption that individuals cannot be harmed once they are dead is reasonable in the case of brain-dead protocols, we argue that the DDR is not an acceptable strategy to protect donors from harm in DCD protocols. We propose a threefold alternative to justify organ procurement practices: (1) ensuring that donors are sufficiently protected from harm; (2) ensuring that they are respected through informed consent; and (3) ensuring that society is fully informed of the inherently debatable nature of any criterion to declare death.

Keywords: brain, end-of-life issues, organ transplantation

The dead donor rule (DDR)—that individuals must not be killed by organ retrieval—describes a moral standard implicitly guiding organ procurement legislations around the world. By embracing the dead donor rule our societies reassure themselves that severely compromised patients will not be killed by being used as organ sources prior to their death (Arnold and Youngner 1993). The DDR also plays the role of relieving society from the fear that donors may have the potential for experiencing harm during organ procurement surgery—the general assumption being that individuals cannot be harmed once they are dead. Although the DDR is deontologic in nature, in that it elicits a duty to prevent exploitation and forbids organ retrieval to be the cause of death, it also has a consequentialist dimension (Robertson 1999; Miller, Truog, and Brock 2010). The DDR protects organ procurement teams from the charge of murder and, in doing so, keeps medical practices away from the spectrum of the slippery slope that might be created if an exception to the prohibition of killing for social purposes were accepted. Hence, the DDR helps to maintain public trust in organ transplantation.

Insofar as the DDR is intimately related to the notion of death, discussions about it are necessarily linked to the complex controversies surrounding the definition of death and the medical criteria employed for its determination. Virtually all modern countries currently accept a “bifurcated legal standard” to declare death: irreversible cessation of circulatory and respiratory function and irreversible loss of all brain function (Capron 1999, 7). In practice, either of these two conditions is considered sufficient for an individual to be declared dead and, if there is no family objection, to be treated as an organ donor. For example, it is legal to procure the heart from those who have irreversibly lost all brain function while their heart is still beating and there is blood circulating throughout their bodies. It is also legal to procure other vital organs, such as kidneys or the liver, employing donation after circulatory death (DCD) following the cessation of circulatory function but without the rigorous neurological examination required under brain death protocols (Institute of Medicine 1999).

The justification for each criterion and a number of medical and philosophical issues regarding the relationship between them generate concern that the bifurcated legal standard for declaring death may be allowing organ procurement in ways that already violate the DDR (Menikoff 1998; Rady, Verheijde, and McGregor 2007; Marquis 2010; Miller, Truog, and Brock 2010). The claim that perhaps the DDR is not being respected—despite the fact that donors are commonly described as “deceased”—is the tautological result of assuming that these individuals may be alive. Thus, it is important to evaluate both whether and how these practices may be currently violating the DDR and to examine whether such a violation is acceptable.

In both brain death and DCD protocols, the potential violation of the DDR is troublesome for those who are concerned about its deontologic dimension, as well as for those who think that the rule is crucial in maintaining social trust in organ transplantation. Regarding the question of why violating the DDR is problematic, it is important to distinguish
between brain death and circulatory death organ procurement protocols. There is general agreement that brain-dead individuals are beyond harm. This implies that if brain-dead individuals were considered to be alive, organ procurement from these patients would still not necessarily threaten the fundamental need to preserve the interests of the donor at the moment of organ procurement. By contrast, in some DCD protocols, concerns about the DDR include the possibility of brain circulation being reestablished and the uncertainty of whether the brain could theoretically still be functioning to some degree at the moment of organ retrieval (Shemie 2007).

The objective of this paper is to discuss whether the DDR is needed to protect donors from harm at the moment of organ procurement. We suggest that the assumption according to which individuals cannot be harmed once they have been declared dead is not only unsound but, in the case of DCD, also dangerous for donors’ safety. While the objective of increasing the donor pool without undermining public trust has been the main reason to frame international policies of organ procurement within the limits of the DDR, we argue that this strategy is problematic as it neglects to meet two essential requirements: ensuring that the donor is sufficiently protected and respected, and ensuring that society is fully informed of the inherently debatable nature of any criterion to declare death.

Our proposal has an important implication on how the theoretical debates about organ procurement should be framed. We believe that the fundamental question regarding the criteria used for the procurement of vital organs ought to be posed not as an objective question of when death occurs—as the DDR necessitates—but rather as a moral question regarding the conditions under which it could be morally acceptable to procure vital organs from dying patients. By shifting the focus in this way, discussions of organ procurement would center more on the interests of donors and less on the seemingly unanswerable question of when death occurs. In this reconceptualized discussion, whether or not organ procurement practices breach the DDR may be of little moral significance.

REDEFINING DEATH: AN IDEOLOGICAL STRATEGY FOR INCREASING THE DONOR POOL WHILE PROTECTING THE DDR

In the last 40 years, introducing medical-legal modifications on the criteria for determining death has turned out to be a successful way to increase organ donation. However, these modifications have not existed without a great deal of perplexity and conceptual dissatisfaction. As the criteria for determining death become less strict and more inclusive, the donor pool widens. However, in so doing, organ procurement is progressively performed at times where the patient is closer to the cusp between life and death.

The adjective “dead” is generally understood by most scholars and policy makers as referring to an objective state of the body, rather than a moral status bestowed by society (Marquis 2010). However, it remains as an open question whether death ought to be considered a natural and objective fact rather than a social construction. In other words: Are donors declared dead because we call them so by virtue of normative reasons, or are they dead regardless of our concepts and rules? As Youngner and Arnold have suggested, the unresolved debates concerning death might be partially due to the difficulty of handling the practical consequences of death being a hybrid phenomenon with one foot in biology and the other in culture (Youngner and Arnold 2001). While reliable data regarding when a brain is totally destroyed or when circulatory function will not recover spontaneously uncover relevant information about the medical conditions of human organisms, this objective knowledge will always be insufficient to resolve the more fundamental question of whether these situations really equate to human death. As K. Gervais pointed out in her book Redefining Death, a morally relevant “decision of significance” is implied in the claim that irreversible loss of brain—or circulatory, we add—function equates to human death. A decision of significance involves the moral and metaphysical conceptions about life that may explain why some biological functions, and not others, are so important for human life that their loss necessarily implies human death (Gervais 1986).

We suggest that both the traditional arguments to include the neurological criteria in the definition of death and the more recent arguments for redefining “irreversibility” in DCD are scientifically and conceptually flawed strategies to convey the acceptability of organ procurement without violating the DDR. Any attempt to meet organ shortage by way of redefining death, insofar as it fails to recognize its dependence upon a normative decision of significance, inevitably hides its normative foundations and thereby rules out any ethical disagreement or debate, given that people are not supposed to disagree about matters of fact. The traditional strategy to increase organ donation has certainly proved very efficient, but not without simultaneously falling into ideology.

ARE BRAIN-DEAD DONORS REALLY DEAD?

Adding the neurological criterion for declaring death to the traditional cardiorespiratory criterion was the strategy chosen by the Ad Hoc Committee of Harvard Medical School in 1968 to address the resulting advances in mechanical respiration and to increase the donor pool in a way that would avoid controversy in obtaining organs for transplantation (Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death 1968). Although heart-beating “brain-dead” donors are in most countries the main source of organs for transplantation, lay people, bioethicists, and professionals involved in organ transplantation have long expressed their concern with regard to whether these patients are dead or alive (Siminoff et al. 2004; Veatch 2005; Youngner et al. 1989). The discovery that brain-dead individuals can maintain several integrative functions including circulation, hormonal balance, temperature control, and metabolism of food with the aid of mechanical ventilation (Halevy and Brody 1993; Shewmon 2001; Truog 2007) has
increasingly been accepted as enough evidence for believing that the mainstream rationale for equating total brain failure to death—death being defined as the irreversible loss of integrative functions of the organism as a whole—is empirically and theoretically flawed (President’s Council on Bioethics 2008; Shewmon 2009).

These problems have led scholars to support organ retrieval from brain-dead patients by way of two main justifications. The President’s Council on Bioethics has argued for the necessity of a new definition of death: “the cessation of the fundamental vital work of a living organism—the work of self-preservation, achieved through the organism’s need-driven commerce with the surrounding world” (President’s Council on Bioethics 2008). This alternative has been acknowledged to be the best available rationale to equate the destruction of the entire brain to death, but has also been thoroughly criticized as being a vague, arbitrary, inconsistent and counterintuitive “contortion of semantics” intended “to save the neurological standard at all intellectual costs” (Shewmon 2009, 20). A second justification has been offered by Truog and others, who have claimed that procuring organs from patients with a severe brain injury can be performed in a respectful and protective way, albeit acknowledging that it constitutes an acceptable violation of the DDR (Truog and Robinson 2003). We explore the implications of this proposal throughout this article.

There are clearly unresolved issues regarding the determination of death by neurological criteria in relation to organ procurement. However, organ procurement from brain-dead patients is widespread and is for the most part a fairly uncontroversial practice, certainly due to the fact that neurological death remains a reliable criterion for establishing a prognosis of irreversibility. Where controversy is now focused is in cases of donation after circulatory death (Bernat 2010).

**ARE DCD DONORS REALLY DEAD?**

The controversy surrounding DCD practices also exists in regard to whether they comply with the DDR (Lynn 1993; Zamperetti, Bellomo et al. 2003; Marquis 2010). Advocates of DCD practices claim that procuring vital organs as soon as 75 seconds after circulatory arrest does not violate the DDR because cessation of circulation has become permanent. However, to have “permanently” lost circulatory function is not equal to the conventional meaning of irreversible—viz. that the circulation could not be reversed, which has been the traditional requirement for declaring death (Youngner et al. 1999; Menikoff 1998). Furthermore, this weak notion of permanence in DCD protocols might be allowing organ procurement at times when brain function, including consciousness, may not be irreversibly lost.

To understand the depth of these debates, a brief description of these practices is provided. DCD involves two types of protocols: donation after controlled circulatory death and donation after uncontrolled circulatory death. We first describe each protocol by showing in which ways they may be violating the DDR. We then discuss whether this is morally and socially acceptable.

Controlled DCD protocols primarily involve ventilator-dependent patients with catastrophic brain lesions whose injuries stop short of brain death. Based on the concept of either quantitative or qualitative futility (Burns and Truog 2007), a decision is made to discontinue mechanical ventilation, which, depending on the protocol, may be entirely or partially carried out in the operating room where organs can be removed as soon as possible following cardiac arrest. In some protocols, organs are cooled in situ after the declaration of death (DeVita 1994). In others, catheters are inserted before the declaration of death, after which extracorporeal membrane oxygenation (ECMO) is initiated in order to perfuse the organs (Gravel et al. 2004). A variable period of no-touch time is then required between loss of circulation and the declaration of death, which ranges from 75 seconds (Boucek et al. 2008) to 10 minutes (Kootstra 1995). Controlled DCD is performed in countries such as the Netherlands, the United States, Canada, and the United Kingdom.

Uncontrolled DCD protocols involve patients who suffer an unexpected cardiac arrest and resuscitation attempts are initiated in the field by an emergency team for at least 30 minutes without success. If the patient fulfills organ donation criteria, cardiac massage and ventilation are continued while the patient is transported to a hospital emergency department. At this point, the physician in charge rules out the possibility of the patient’s recovery and decides to stop resuscitation. Five minutes later, in the absence of circulatory function, death is declared and mechanical cardiac massage and ventilation can be transitorily restarted by the transplant team until either in situ cooling or regional ECMO is initiated. Once the organs are being preserved, proxies are asked whether they consent to organ retrieval. Barring any objection, organs are removed. Uncontrolled DCD is prevalent in Spain, but other countries (such as the United States and France) have more recently adopted this modality of organ procurement.

Both types of DCD practices have been considered by some to violate the DDR in several ways. In the following, we present two arguments illustrating how DCD may violate the DDR.

1. The patient is not dead at the moment of organ retrieval because the time of circulatory arrest is too short to ensure that cardiac arrest is irreversible.

Although this argument is based on an empirical claim regarding the necessary and sufficient time to guarantee that the loss of circulatory function is irreversible, the meaning of “irreversible” is problematic. While the dictionary definition of irreversible refers to some process that is “not able to be undone or altered” (Oxford Dictionaries), controlled DCD protocols have embraced a weaker construal of “irreversible,” i.e., “permanent cessation.” As we see, according to this weaker construal, individuals can be declared dead at times where their vital functions could still
be reversed. Some have raised the suspicion that the motivation to abandon the standard conception of irreversibility in controlled DCD is that the amount of time necessary to prove such irreversibility “would be sufficiently long so to damage significantly the other organs [other than the heart], thus making them less useful for transplantation purposes” (Menikoff 1998, 158). Downie and colleagues interpreted the term “irreversible” even further, as “will not be reversed without violating the patient’s decision or the law on consent” (Downie et al. 2009, 858). However, this interpretation contradicts the idea that irreversibility is a condition that does not depend on contingencies such as availability of technical resources or human decisions and conventions.

Bernat, a strong advocate of both DCD and the DDR, believes that permanent cessation is a valid surrogate indicator for irreversible cessation (Bernat 2010). Thus, according to him, the requirement for irreversibility is not that circulatory function could not be restored by anyone under any circumstances and at any time, nor even a weaker interpretation that circulatory function cannot be restored by those present at this time, but only that circulatory function will not be restored. Is this weaker construal of irreversible scientifically sound? Is it morally acceptable?

Studies on the potential for actively restarting human hearts following asystole have demonstrated the ability to restart human hearts up to 6 hours ex vivo after cardiac arrest (DeVita 2001). If a strong interpretation of irreversibility such as this is followed, controlled DCD would clearly violate the DDR. To avoid this objection, Bernat and colleagues argue that electrical cardiac activity alone is usually irrelevant in death determinations, and only the return of spontaneous circulation of blood through the body must count as meaningful resuscitation (Bernat 2010). This type of resuscitation would be referred to as autoresuscitation (AR).

The likelihood of spontaneous recirculation depends on whether the patient has previously undergone cardiopulmonary resuscitation (CPR). This is relevant for distinguishing the assessment of irreversibility of circulatory function in controlled DCD and in uncontrolled DCD. In a recent systematic review of the literature on this subject, Hornby and colleagues conclude that they “did not find any studies that reported the occurrence of AR in the absence of CPR,” but that it has been reported to occur “from a few seconds to 33 mins after failed CPR” (Hornby et al. 2010, 1248). Although the evidence suggests that the likelihood of AR would be lower in controlled DCD, the authors acknowledge that the studies that have analyzed this are “very-low quality” and recommend “the need for additional potential methods of evaluating the ‘time to death’ question after withdrawal of life support” (Hornby et al. 2010, 1251).

The ordinary concept of irreversibility would require that, if an organism stops functioning but its functioning could be recovered by means of a device that we do not in fact possess, or that we do possess but decide not to use, it is not dead (McManus 2006). Permanent loss of circulatory function is the weakest possible meaning of “irreversibility,” for it merely means that resumption of cardiac rhythm and contraction will not take place, although it could. In controlled DCD, the ultimate reason why the patient’s circulatory function will not be restored is that a decision has been made not to reverse her condition. Such a decision is certainly morally defensible in the context of controlled DCD where the patient would have undergone the withdrawal of life support anyway. However, it is questionable whether a moral claim on what ought to be is, in itself, the appropriate type of rationale to determine what is usually meant to be understood as an objective occurrence: somebody’s death.

Recently, Marquis has convincingly argued that normatively redefining “irreversibility” in terms of “permanence”—as proposed by Bernat and others—in order to protect the DDR in DCD leads to a great deal of perplexity. Although “irreversible” applies to absolutely unalterable phenomena (e.g., death), “permanent” is a contingent property dependent on contextual factors such as availability of resources, human intention to reverse a condition, or, as happens in controlled DCD, an existing moral agreement that resuscitative attempts in these patients should not be performed (Marquis 2010). One consequence of allowing moral claims to determine the clinical diagnosis of death is that two individuals sharing an identical medical condition could have different vital statuses according to the intentions of their physicians or the contingency of a dominant moral consensus. Another perplexity that has resulted from having accepted permanent loss of circulatory function as a surrogate of irreversible loss is that patients declared dead according to circulatory criteria after 75 seconds of cardiac arrest have been able to be heart donors (Boucek et al. 2008). Veatch has called this “reversing the irreversible” (Veatch 2008, 672).

2. The patient is not dead at the moment of organ retrieval because brain death is not rigorously demonstrated and can only be assumed in DCD.

Another substantial problem is the possibility that a DCD donor could be declared dead even though that person’s brain may conserve the potential for functioning to some extent. This concern raises the question of the relationship between brain death and circulatory death. In fact, the standard tests used for the determination of brain death are not used in either controlled DCD or uncontrolled DCD. Only a clinical evaluation, without confirmatory tests, is legally required (Institute of Medicine 1999). It has been questioned whether the waiting periods in existing protocols are enough to ensure total brain failure—that the functions of the entire brain are irreversibly lost—especially as DCD may occur in the absence of a prior brain injury (Menikoff 1998). In both DCD protocols, the assumption is that, in the period between cessation of circulatory function and the determination of death, loss of all brain function has also become irreversible (Capron 1999). Advocates of DCD thus claim that those protocols do not violate the DDR because loss of circulation quickly results in irreversible loss of brain function if no attempt to restore cardiac activity is undertaken (Bernat 2010)
In fact, brain activity can actually be restored if the appropriate empirical means are initiated. Unfortunately, the only rigorous empirical evidence we have of this is from animal experimentation. Such studies indicate the possibility of successful resuscitation and restoration of normal cerebral function after 11 minutes of cardiac arrest (DeVita 2001). Moreover, the use of ECMO in these protocols could actually restore some brain function by restoring blood flow to the brain after the patient has been declared dead (Shemie 2007). Bernat and colleagues have acknowledged this problem:

The use of ECMO in the [DCD] donor creates a problem with death determination because it retroactively negates the physiologic justification for declaring the [DCD] donor dead. By allowing reperfusion of the brain and thereby preventing brain destruction, it interrupts the otherwise inevitable progression from permanent loss of circulation and respiration to irreversible loss. Restoring brain circulation also raises the possibility of retaining donor consciousness and the consequent potential for suffering. (Bernat et al. 2010, 967)

Some have suggested that the insertion of an aortic occlusion balloon catheter via the femoral access and advanced to the lower descending thoracic aorta in DCD would avoid reperfusion of the brain through ECMO (Gravel et al. 2004). A credible argument to justify this maneuver is to prevent any possibility of restoring brain function. If this is correct, it demonstrates that the loss of all brain functions in these protocols cannot be considered irreversible, and that permanent loss is not a valid surrogate for irreversible loss.

THE FAILURE OF REDEFINING DEATH

Both traditional attempts to demonstrate that brain-dead donors are dead and more recent ones to claim that DCD donors are dead (by virtue of “permanent” being used as a surrogate for “irreversible”) have failed to offer any kind of scientific certainty and value-free rationale for such claims. Analytic scrutiny reveals that these attempts ultimately depend on moral assumptions that are, as such, debatable. Pretending that these patients are dead, however, masks the normative component of these proposals. This impedes any ethical discussion: As people are not supposed to debate descriptive-like claims on which they lack enough knowledge, the public is unlikely to discuss these apparently value-free decisions. This probably explains why conceptually manipulating the criteria to declare death has turned out to be for many years a successful way to increase organ donation in our societies. However, to pretend that permanent loss of circulatory or brain function really equates to human death grants medical science a power that it does not deserve, disguises moral judgments by pseudo-objective claims, and palns the very normative nature of the question: Under which conditions would it be morally acceptable to procure vital organs from dying patients? This strategy plays the crucial role of influencing public attitudes toward organ donation, but for doing so it requires distorting the normative nature of any declaration of death and subsequently discourages all critical reflection on these practices. We believe that this “sedative” kind of policy is close to what Karl Marx used to call ideology.

When considered carefully, this masking strategy also generates important theoretical and practical problems. In the neurological determination of death, as well as in DCD, modifying the criteria for death has led to confusion and contradiction. Most importantly, in DCD protocols, this strategy also risks being harmful to donors. DCD protocols may compromise the donors’ interests not because they are alive (brain-dead donors may also be considered alive), but because they may have not irreversibly lost all brain functions, including those responsible for the capacity of experiencing harm. Even with an aortic occlusion balloon catheter present, the patient could theoretically suffer if the balloon deflates or is ineffective in any way.

The possibility of reinstituting brain blood flow in DCD raises concern at two levels. On the one hand, it brings into question the conceptual unity between the two legally accepted standards for determining death—brain death and circulatory death—by suggesting that the former is crucial while the latter is not. On the other, it makes it clear that calling a donor “dead,” by itself, does not prevent that individual from suffering.

THE DEAD DONOR RULE: RESPECTING THE RULE WITHOUT CARING ABOUT THE REASONS FOR DOING SO

The insistence on making organ procurement policies compatible with the DDR has diverted the attention of scholars and policymakers from the legitimate motivations of the DDR (i.e., the aim to protect and respect all donors and to preserve public trust), to the mere letter of the rule. The DDR encourages the intuitive but dangerous inference that because a patient has been pronounced dead, there is no moral objection to procuring her organs. In a response to Marquis, Bernat claims: “Because this practice [DCD] is encompassed in a UDDA [the Uniform Determination of Death Act] provision requiring death determination to be ‘in accordance with accepted medical standards,’ declaring death on DCD donors does not violate the dead donor rule” (Bernat 2010, 3). While this evaluation may be logically valid, one may still wonder if this is a morally satisfactory argument. If this was the extent of our moral investigation—if our only concern was to respect the rule without caring about the reasons for respecting it—then we could be satisfied that DCD practices formally conform to the DDR and are legal. On the other hand, if we are morally committed to the important moral values that motivated the implementation of the DDR (the duty to avoid exploitation and harm, and to prevent a loss of the social endorsement on organ donation), then further empirical and ethical investigation is required. We have claimed in this article that DCD practices dangerously act in violation of the DDR’s reason to be.

On the one hand, the theoretical possibility for restoring brain blood flow in patients diagnosed with a permanent circulatory arrest suggests that the traditional circulatory criterion should never have been considered a sufficient
condition for considering a patient as a vital organ donor. If current laws encourage the procurement of organs from individuals whose brain function is not irreversibly lost, we may then argue that current laws need revision. Indeed, Shewmon has recently advocated for a “semantic bisection” of the concept of death, making a distinction between “passing away,” a sociolegal distinction, and “deanimation,” an ontological or theological “ceasing-to-be” of the entire organism (Shewmon 2010). On the other hand, if we focus on the interests of the patients rather than trying to persuade ourselves into believing that death has occurred, considerations that protect patients from harm, such as anesthesia, may become quite important. This has been considered as a way to ensure that the donor does not suffer during vital organ procurement (Wilkinson and Savulescu 2010). Although there may be a problem of incompatibility between anesthesia and the occlusion of the aorta—as anaesthesia usually necessitates circulation to the brain—according to Miller, Truog, and Brock (2010), “It is difficult to see how they can be harmed or wronged by vital organ donation with valid consent, provided that adequate anesthesia is maintained during organ extraction and treatment withdrawal” (306). More studies on how brain lesions affect the possibility for reversing the capacity for consciousness in patients who undergo artificial circulation would be very useful in these debates.

**WOULD BURYING THE DDR BE SOCIALLY ACCEPTABLE?**

Obedience to the DDR has induced policymakers to include and maintain irreversible loss of brain function as a legal criterion for declaring death despite controversies and some evidence that these individuals do not fulfill any definition of death. Reverence to the DDR also compels health professionals to declare potential DCD donors dead before they have irreversibly lost their capacity for experiencing harm. Because there is a general assumption that dead individuals cannot be harmed, veneration of the DDR is dangerously misleading. Ultimately, what is important for the protection and respect of potential donors is not to have a death certificate signed, but rather to be certain that they are beyond suffering and to guarantee that their autonomy is respected. The DDR hardly serves these morally necessary purposes. Rather, it might be pulling our attention from them.

If our analysis is correct, the DDR does not serve the best interests of potential donors. However, other questions remain. Is it the best possible way to maintain social trust in organ procurement? Are our societies ready to accept vital organ procurement before declaring potential donors dead?

It is hard to predict the reaction of the public if organ procurement were practiced in the absence of the DDR. Certainly, a number of people would initially consider this possibility outrageous. In fact, the public’s response would depend on how the population is engaged and informed regarding these issues. One must ask which, among all the reasons to endorse the DDR, are the most important for our society. This is an empirical question that would need our attention if we were to abandon the DDR. Few studies have addressed the question of whether society would consider acceptable the procurement of vital organs from patients before they are dead. A study by Siminoff, Burant, and Youngner (2004) demonstrated that a third of a sample of more than a thousand inhabitants in Ohio seemed to be willing to donate the organs of scenario brain-dead, vegetative state, or even comatose patients they described as being alive. In another study, 95% of nurses agreed that DCD donors should have access to pain medication, with 92% believing this to be the case even if death is hastened (Mathur et al. 2008). It is important to note that while some people seem to accept de facto violations of the DDR, this does not necessarily mean that they would also support a law authorizing these violations (Veatch 2004).

We contend that organ donation can be performed in a morally acceptable way, while maintaining public trust in organ procurement, if the following conditions are met. Importantly, donors must be satisfactorily protected and respected, and the public must be engaged and informed. One way to respect the donors in pluralistic societies is to have them participate in the value-laden decisions that medicine takes regarding the end-of-life. The best way to protect donors is by ensuring that they are beyond harm. If donors are beyond harm and had given appropriate consent for donation, would it really be necessary to call them “dead” for the organ procurement to take place? Yes, if we believe that people should never be intentionally killed for social purposes. Not necessarily, if the distinction between killing and allowing death is considered to have little moral significance (Youngner and Arnold 1993; Miller, Truog, and Brock 2010). In any case, is it better to call them dead and consequently be satisfied with the illusion that they cannot suffer as a result of our diagnosis? Perhaps situations where patients are beyond suffering and have consented to donation may be considered a form of living donation. At any rate, rigorous informed consent, protection from harm, and transparency toward the public could constitute a threefold pillar on which organ procurement of vital organs could operate in an ethically acceptable and socially responsible way.

We believe that justifying the procurement of vital organs from severely injured patients on an explicit moral basis, instead of supporting it on the pseudo-objective claim that “they are really dead,” is an honest way to acknowledge the unavoidable uncertainty of the vital status of so-called “brain-dead” and “circulatory-dead” donors. It avoids hiding the inevitable controversies on the vital status of potential donors behind tendentious language disguised by apparently objective claims. It avoids pursuing the noble goal of organ procurement at the price of ideological policies that palm bioethical deliberation.

Informed consent is important because respect for autonomy is generally considered to be the only moral basis that can justify exceptions to the principle of nonmaleficence. For instance, it is the main moral condition justifying voluntary euthanasia, living organ donation, and experimentation with healthy human subjects. Limiting DDR violations to cases where the donor consents is thus a way to
limit exploitation. It is also a way to limit the potential for a slippery slope which might be created if killing for social purposes was ever accepted. Respecting autonomy through informed consent is necessary but not sufficient. While appropriate informed consent is the best tool to respect organ donors beyond the limits of the DDR, it is not sufficient to protect them from harm (e.g., people can consent to interventions that can harm them). This is why being beyond harm—or ensuring that the individual could not experience pain through the process of organ donation—is needed as a complementary requirement for these protocols to ensure that donors are not only respected, but also protected. Being beyond harm would also limit the specter of the slippery slope, because only a limited number of patients who are totally unconscious and are not likely to recover consciousness would be candidates for vital organ donation.

It is recognized that differentiating what is allowed from what is forbidden on the basis of explicitly acknowledged moral criteria certainly raises some risks and challenges. We acknowledge that any proposal of a moral justification for the procurement of vital organs is not less debatable than any unscientific rationale for equating “brain death” or “circulatory death” to death. Our proposal offers, however, one advantage: The debatable nature of its grounds is at least explicit enough to encourage the discussion; to avoid bringing this moral controversy to a close before it has taken place. If our argument is reasonable, then one possible response to these controversies may be to simply bury the dead donor rule. The standard alternative—further manipulating our language about death in order to conform to the DDR—has proven not only to be conceptually indefensible, but also too risky.

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