



## PHILOSOPHY AND THEOLOGY

Given the increasing desire for life-saving transplantation, proposals aiming to bridge the gap between supply and demand of donated organs continue to be circulated. “The greatly enhanced technical ability to transplant organs has also led to an ever-increasing need for transplantable organs. The explosive growth in the demand for and the marginal increase in the supply of transplantable organs have together been characterized as an ‘evolving national health care crisis.’”<sup>1</sup> In the United States alone, approximately one hundred thousand patients are on transplant waiting lists, but each year only ten to twenty thousand receive organs (Thomas D. Harter, “Overcoming the Organ Shortage: Failing Means and Radical Reform,” *HEC Forum*, June 2008).

One way in which this gap could be narrowed is by making more use of organ donation after cardiac death (DCD). “Many patients in the intensive care unit will die of these very same neurological diagnoses but never satisfy criteria for brain stem death. It is by utilizing this new population of potential donors that NHBD [non-heart-beating-donation] may substantially increase the organ donor pool.”<sup>2</sup> M. D. Bell estimates that the organ pool could be increased by 25 percent through DCD, a possibility which generates considerable pressure to increase DCD.<sup>3</sup> As J. L. Verheijde, M. Y. Rady, and J. McGregor note, a “federal mandate requires hospitals as of January 2007 to design policies and procedures for organ procurement in DCD

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<sup>1</sup>J. L. Verheijde, M. Y. Rady, and J. McGregor, “Recovery of Transplantable Organs after Cardiac or Circulatory Death: Transforming the Paradigm for the Ethics of Organ Donation,” *Philosophy, Ethics and Humanities in Medicine* 2.8 (May 2007): 1.

<sup>2</sup>D. Gardiner and B. Riley, “Non-Heart-Beating Organ Donation: Solution or a Step Too Far?” *Anaesthesia* 62.5 (May 2007): 431.

<sup>3</sup>See M. D. Bell, “Non-Heart Beating Organ Donation: Old Procurement Strategy—New Ethical Problems,” *Journal of Medical Ethics* 29.3 (June 2003): 177.

to increase the rate of organ donation and recovery from decedents to 75 percent or greater.”<sup>4</sup>

Concerns about whether neurological criteria can properly define death also drive interest in DCD as an alternative to transplantation following brain death (see D. Alan Shewmon, “Brain Death: Can It Be Resuscitated?” *Hastings Center Report*, March–April 2009). The early years of organ transplantation made use of cardiopulmonary criteria in determining death. Following the 1968 Harvard Medical School Ad Hoc Committee report, death began to be defined in terms of loss of brain function, either whole brain or even just higher-brain function. Even though in current practice the majority of transplantation comes from donors declared dead by the use of neurological criteria, organ donation still takes place through the application of cardiopulmonary (circulatory-respiratory) criteria in determining death. However, if we are to retain the dead-donor rule and if the critics of brain death are correct, then the use of circulatory-respiratory criteria to determine death becomes not just a possibility but a necessity for organ donation purposes. (For a critique of brain-death criteria, see Franklin G. Miller and Robert D. Truog, “The Incoherence of Determining Death by Neurological Criteria: A Commentary on *Controversies in the Determination of Death*, a White Paper by the President’s Council on Bioethics,” *Kennedy Institute of Ethics Journal*, June 2009.)

Unfortunately, three sorts of ethical questions have been raised about DCD itself. First, is there a necessary conflict of interest between providing optimal care for the patient donating organs and looking to benefit the organ recipient? Second, is it permissible to alter care for the donor prior to death solely for the sake of the organ recipient or are such interventions in violation of the maxim always to respect humanity as an end in itself and never use any person simply as a means? Third, at what point can we declare death by means of circulatory-respiratory criteria?

The first question is whether there is a necessary conflict of interest in DCD between providing the best care for the organ donor and looking after the interests of the organ recipient. The potential for conflict is certainly possible, since a physician may neglect to properly care for, or even kill, one patient in order to get viable organs for another patient. Transplantation practices in Sweden may provide a model for resolving potential conflicts of interest. (See K. Zeiler et al., “The Ethics of Non-Heart-Beating Donation: How New Technology Can Change the Ethical Landscape,” *Journal of Medical Ethics*, July 2008.)<sup>5</sup> In Sweden, medical professionals are strictly forbidden from asking about or discussing the donor status of a patient (whether pro or con) during the course of treatment. After death is declared, the health care team checks the national registry for advance directives to find out whether the patient consented to organ donation. This way of proceeding avoids

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<sup>4</sup>Verheijde, Rady, and McGregor, “Recovery of Transplantable Organs,” 2.

<sup>5</sup>In the Swedish approach, the individual decision whether or not to be an organ donor takes precedence, but in cases in which there is no directive either for or against donation, the presumption is that the person would consent to organ donation and donation is done unless the family objects.

conflicts between providing the best care for the dying patient and looking to secure organs for needy organ recipients. Since the donor status of a patient is unknown prior to death, physicians and others have no incentive to provide less than optimal care for donors. A physician in such a case simply does not know whether the patient is a potential organ donor, so considerations about benefiting a potential recipient cannot cloud the physician's judgment.

A second question relevant for DCD concerns antemortem interventions. In the case of antemortem interventions, the patient is still alive but is given treatments in order to prepare his organs for transplantation to benefit the organ recipient. Is it ethically permissible to perform procedures on the donor while the donor is still alive solely for the sake of the organ recipient? Such inventions are possible only in controlled DCD, for in uncontrolled cases of DCD the patient has already died. The ethical concern with antemortem interventions is that it is morally wrong for one person (the donor) to be used simply as a means to aid another person (the organ recipient). DCD would seem to violate the widely held maxim that humanity, whether in one's own person or in another, is always to be respected as an end in itself and never used simply as a means. If DCD is permitted, basic treatment needed to sustain life may be withdrawn, simply to secure more organs.<sup>6</sup> Nancy Valko suggests that the patients may be pressured into "pulling the plug" so as to make themselves useful as sources of organ donation. There is an apparent conflict between implementing the Swedish protocol just described and doing any antemortem interventions whatsoever. However, if we modify the Swedish Transplantation Act to say that no inquiry may be made into donor status until the patient has died or the patient has decided to remove life-sustaining treatment, this difficulty is avoided, as are Valko's concerns of Valko. However, in cultural contexts such as our own, in which the basic human dignity of all human beings is frequently denied, this concern—that DCD dehumanizes patients in their final hours—are serious.

These concerns are amplified by the views of some (but not all) advocates of DCD. For example, James F. Childress considers such people "better off dead than alive with severe pain and discomfort."<sup>7</sup> Childress's view is undifferentiated. Severe pain and discomfort are evils—evils that exist only in living beings. However, it does not follow from this that life itself is evil, or that people in severe pain would be better off dead. Life is an intrinsic good, because bodily life is a constitutive element of what it is to be a human being, and to be a human being is always good. Similarly, knowledge of a painful truth causes suffering and hardship, but it does not follow that people would be "better off without intelligence" or that intelligence itself is sometimes an evil, even though it is true that in eliminating human intelligence certain kinds of suffering would thereby also be eliminated. Human life is good, it is not

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<sup>6</sup>See Nancy Valko, "Ethical Implications of Non-Heart-Beating Organ Donation," *Human Life Review* 28.3 (Fall 2002): 109.

<sup>7</sup>James F. Childress, "Non-Heart-Beating Donors of Organs: Are the Distinctions between Direct and Indirect Effects and between Killing and Letting Die Relevant and Helpful?" *Kennedy Institute of Ethics Journal* 3.2 (June 1993): 204.

an evil or not worth living, even though human life is a necessary condition for pain and suffering, and even though in some cases the burdens of some life-sustaining treatment outweigh its benefits.

Childress wonders whether a patient may turn down treatment in order to aid an organ recipient. "One unresolved question is whether altruistic patients who want to increase the chances that their deaths will produce usable organs may choose to alter the care provided in the last few hours of their lives."<sup>8</sup> However, in medical practice, a competent patient may always refuse medical treatments. Therefore, if a competent patient chooses to discontinue or refuse a treatment that in the patient's view was not worthwhile, in order to help an organ recipient, this is not *prima facie* legally or ethically problematic. To refuse continued life-sustaining treatment is not morally wrong so long as it is not chosen precisely as a means to suicide.

Zeiler and colleagues argue that a patient should be treated only for his or her own sake; therefore the use of anticoagulants and other drugs for the sake of the person receiving the donation is prohibited. However, presuming informed consent, neither forgoing treatment judged burdensome by the patient nor taking on bodily risks for the sake of benefiting someone else violates the Kantian maxim of respecting all persons, including oneself, as ends in themselves and never using them simply as a means. In the case of kidney donation, for example, the donor freely chooses to undergo risks of various kinds—including surgery and future reliance on a single kidney—in order to aid another person, yet because this sacrifice for the good of another is freely chosen, it embodies rather than undermines innate human dignity. Using a person simply as a means treats the human person as a mere tool or biological material to be manipulated, but in giving free consent the donor acts as an autonomous person. Of course, not every autonomously chosen action is compatible with proper self-regard. For example, suicide committed to provide organs for another is morally impermissible, for it is making use of oneself simply as a means as if every innocent human life were not inviolable. However, risking one's own well-being to help another is heroically generous. By contrast, committing suicide in order to give non-duplicate vital organs to another violates the principle that every innocent person, including oneself, should not be intentionally killed.

But perhaps precisely this principle can be used to argue against antemortem interventions in DCD cases. If one may not intentionally kill or hasten death, even to aid another person, then if DCD necessarily involved either, it would be wrong. In uncontrolled cases of DCD, these issues are not relevant, since it is impossible to kill, or hasten the death of, an already dead patient. However, in controlled DCD cases, one could argue that removal of life support is intentional killing or intentional hastening of death.

The removal of life support may indeed, in some cases, violate the sanctity of life, but it need not in all cases be intentional killing. If the removal of life support is simply the means chosen to kill the patient, it would indeed be wrong and simply a form of euthanasia. However, if the life-supporting treatment is removed because

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<sup>8</sup>Ibid., 210.

the treatment, not the patient, is judged more burdensome than beneficial, then such removal is moral. Removal of life support in such cases does not involve a homicidal intent, even if it is certain the patient will die. If removing life support even in cases where death will certainly follow can be permissible, how much more is the administration of antemortem interventions, which may only risk hastening death permissible. Typical antemortem interventions in DCD cases include the administration of heparin or phentolamine, and cannulation. I could find no conclusive evidence that these interventions necessarily hasten death in potential non-heart-beating donors. However, many authors point to the risks of such interventions, perhaps even lethal risks.<sup>9</sup>

Assuming that antemortem interventions risk death, they may still be justified by double-effect reasoning. First, it is not intrinsically evil to do an action that risks death, including fighting fires, serving in the military, or taking a potentially lethal medication to preserve life or health. Second, if death comes about, the death in the DCD case is not a means to the end of helping the organ recipient, since the hastened death is not what makes the organs suitable for transplantation. True, the patient must be dead if the dead-donor rule is to be respected, but the timing of the death is not normally essential to the organ donation. In other words, if the organ donor dies a few minutes sooner rather than a later, this timing of death is not a means to the organ donation but a side-effect of preparing the organs for donation. Third, the evil of hastened death is not intended as either a means or an end in itself. In other words, the physician is not necessarily seeking, endeavoring, or willing the early death of the patient so as to facilitate organ transplantation. Again, the timing of the death of the donor is not relevant for successful organ transplantation. Finally, there exists a serious reason for allowing the possible evil effect, namely, saving the life of the organ recipient.

Steinberg objects that “the principle of double effect can be manipulated because the notion of what it intended is both malleable and subject to the whims of human consciousness. The same act may be permissible or impermissible depending on what enters a physician’s consciousness.”<sup>10</sup> In other words, double-effect reasoning leads to ethical doublethink, in which what is wrong is made right simply by power of mind.

Steinberg’s objection does not adequately capture double-effect reasoning properly understood.<sup>11</sup> If an agent literally is unaware of an aspect of an action, if this effect is not at all a part of the agent’s plan or even consciousness, then the agent

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<sup>9</sup>See Bell, “Non-Heart Beating Organ Donation,” 179; and David Steinberg, “The Antemortem Use of Heparin in Non-Heartbeating Organ Transplantation: A Justification Based on the Paradigm of Altruism” *Journal of Clinical Ethics* 14.1–2 (Spring–Summer 2003): 19.

<sup>10</sup>Steinberg, “Antemortem Use of Heparin,” 20.

<sup>11</sup>Perhaps the best single resource for this understanding is Thomas Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (New York: Oxford University Press, 2006).

is ignorant of that effect. Ignorance, of course, comes in two varieties—culpable and inculpable. If the agent is inculpably ignorant of an evil effect, then no moral guilt is incurred and the action as performed by the agent is not morally defined by that effect. If the agent is culpably ignorant, then the agent is ethically responsible for what occurs, for the agent could have and should have been aware of the effect. However, what is intended or not intended does not shift simply as a result of one's mental focus. What is knowingly chosen as a means to an end or as an end in itself is always intended—regardless of what narrative the agent constructs to somehow transform a means into a side-effect, regardless of which effects the agent was “focusing” on in consciousness, regardless of whether the agent regrets or delights in the given effect. What an agent intends corresponds to the actual means and actual ends chosen as a part of agent's practical reasoning.

A third question facing controlled DCD is, when does irreversible loss of cardiopulmonary function take place? No single, universally accepted standard exists for the determination of death by cardiac criteria. Patients are declared dead in less than two minutes of asystole (cardiac standstill) in many intensive care units. The Pittsburgh protocol for DCD insists on two minutes; the Institute of Medicine five minutes, and the Maastricht protocol ten minutes. The foremost critic of brain death, D. Alan Shewmon, believes that normally the “point of no return” is twenty to thirty minutes following loss of circulation.<sup>12</sup>

If we adopt the most demanding standard, twenty to thirty minutes, then we have greater assurance of not violating the dead-donor rule. Adopting this standard may also increase the likelihood of public confidence that transplantation itself does not kill donors, a perception that may increase the number of people who are willing to be donors. By contrast, less demanding standards may increase public perception that organ transplantation kills one person to aid another, driving down the number of willing donors and further exacerbating the organ shortage.

Is the demanding standard of twenty to thirty minutes compatible with retrieving viable organs for donation? DCD most often involves the donation of kidneys and livers.<sup>13</sup> Fortunately, these organs remain viable for donation, “up to forty minutes after cessation of heartbeat. (Kidneys and livers are more resilient to oxygen deprivation than other organs).”<sup>14</sup> DCD can also be used for lung transplantation: “The gas exchange system of the lungs can tolerate one hour of warm ischemia after circulatory arrest without significant loss of functional capacity.”<sup>15</sup> What about DCD for heart

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<sup>12</sup>See D. Alan Shewmon, “Brainstem Death, Brain Death, and Death: A Critical Re-Evaluation,” *Issues in Law & Medicine* 14.2 (Fall 1998).

<sup>13</sup>See Roger Herdman, Thomas L. Beauchamp, and John T. Potts, “The Institute of Medicine's Report on Non-Heart-Beating Organ Transplantation,” *Kennedy Institute of Ethics Journal* 8.1 (March 1998): 86.

<sup>14</sup>Phyllis L. Grasser, “Donation after Cardiac Death: Major Ethical Issues,” *National Catholic Bioethics Quarterly* 7.3 (Autumn 2007): 541.

<sup>15</sup>Axel Carlberg, “Transplanting Lungs from Non-Heart-Beating Donors,” *National Catholic Bioethics Quarterly* 2.3 (Autumn 2002): 378.

transplantation? “Recently the Papworth hospital group described the first case of functional recovery in a human deceased donor heart following in-vivo perfusion of the coronary circulation with normothermic blood using an extracorporeal circuit. After twenty-three minutes of warm ischemia the asystolic heart was perfused and reverted into sinus rhythm.”<sup>16</sup> Even with the demanding standard, livers, kidneys, lungs, and perhaps even hearts can be retrieved in cases of DCD.

This raises a problem, for if kidneys, livers, lungs, and maybe also hearts are all still viable for transplantation after twenty to thirty minutes of asystole, then the patient would seem to be still alive. In taking the patient’s vital organs, we violate the dead-donor rule. However, if we wait until an hour or two passes, then the patient is certainly dead but the organs commonly retrieved in DCD are not longer viable.

This is a false dilemma. The fact that an organ or even many organs may function well in a donor’s body does not mean that the organ donor is not yet dead. Life consists not in having various organs that can function outside the context of the organism, but rather in the integrated functioning of the organism as a whole. Imagine a special disintegrating machine that destroyed every cell in the human body except for the liver, lungs, heart, and kidneys. A human being disintegrated in such manner is obviously dead, but the organs are nevertheless viable. In a less imaginative example, a human being is no longer alive shortly following decapitation, but the organs of such a person may very well remain viable for transplantation. Organic life consists not in possessing organs that can function in other contexts, but rather in being an organism with integrally functioning organs.

In this essay, I have attempted to briefly answer three main ethical questions arising from DCD. These include concerns about a conflict of interest between providing the best treatment for potential donors and facilitating organ transplantation, worries about the use of antemortem drugs to facilitate organ transplantation, and uncertainties about determining death by means of cardiopulmonary criteria. These reasonable concerns should give pause to advocates of DCD, but the ethical difficulties appear to be surmountable. Properly carried out, DCD is, in my view, ethically permissible even if it remains from a medical point of view technically difficult to successfully perform.

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<sup>16</sup> Ashley Laboratory, “Deceased Donor as a Source for Organs for Heart Transplantation” (2009), Stanford University School of Medicine, [http://ashleylab.stanford.edu/projects/physclin/non\\_heart\\_beat\\_donor.html](http://ashleylab.stanford.edu/projects/physclin/non_heart_beat_donor.html).

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**JOURNALS IN PHILOSOPHY  
AND THEOLOGY**

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**American Journal  
of Bioethics**

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Volume 9, Number 8  
August 2009

**Why Consent May Not Be  
Needed for Organ Procurement**

*J. Delaney and D. B. Hershenov*

Most people think it is wrong to take organs from the dead if the potential donors had previously expressed a wish not to donate. Yet people respond differently to a thought experiment that seems analogous in terms of moral relevance to taking organs without consent. The authors argue that their reaction to the thought experiment is most representative of our deepest moral convictions. They realize not everyone will be convinced by the conclusions they draw from their thought experiment. Therefore, the authors point out that the state ignores consent in performing mandatory autopsies in some cases. If readers are willing to give up the permissibility of mandatory autopsies, the authors then offer some metaphysical arguments against posthumous harm. Drawing upon claims about bodies ceasing to exist at death and Epicurean-inspired arguments against posthumous interests, they make a case for an organ conscription policy which respects fundamental liberal principles of autonomy, bodily integrity, and property.

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**Bioethics**

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Volume 23, Number 7  
September 2009

**Ought We to Enhance  
Our Cognitive Capacities?**

*T. Tännsjö*

Ought we to improve our cognitive capacities beyond the normal human range? It might be a good idea to level out differences between peoples cognitive capacities; and some people's reaching beyond normal capacities may have some good side-effects on society at large (but also bad side-effects, of course). But is there any direct gain to be made from having one's cognitive capacities enhanced? Would this as such make our lives go better? No, the author argues; or at least there does not seem to be any evidence suggesting that it would. And it does not matter whether we consider the question from a narrow hedonistic perspective, from a more refined hedonistic perspective, from a desire-satisfaction view, or from some reasonable objective list view of what makes a life go well. Only an extremely perfectionist—and implausible—view of what makes our lives go well could support any direct value in cognitive enhancement. Finally, our sense of identity gives us no good reasons to enhance even our capacity to remember. So cognitive enhancement as such would not improve our lives.

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**Hastings Center  
Report**

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Volume 39, Number 2  
March–April 2009

**Brain Death: Can It Be Resuscitated?**

*D. A. Shewmon*

Why is a patient with a destroyed brain considered dead rather than moribund and irreversibly comatose? The world has been grappling with this question for the past four decades with little success. The recently released white paper of the President's

Council on Bioethics is in many respects a refreshing, thoughtful, and comprehensive reexamination of this complex topic. It offers a very helpful analysis of the major positions on the determination of death, and it proffers a creative new solution of its own. Unfortunately, the new solution does not put the problem to rest, but the humility with which the council discusses its own position and the honesty with which it confronts the consequences of being wrong alone make this report a very commendable document.

Volume 39, Number 3  
May–June 2009

### **The Evolution of Death and Dying Controversies**

*R. M. Veatch*

The controversies surrounding forgoing of life support have sometimes turned out to be more easily resolved than those over the definition of death. Like the debate about defining death, however, today's issues about forgoing life support are almost always more complex and subtle than those of the 1970s. They involve physician-assisted suicide, active killing for mercy, conflicts among plausible surrogates, forgoing implanted devices such as pacemakers that would require active intervention to remove, tensions over which treatments are futile, and controversies involving resource allocation. Unless there is an unresolved angle to a case, we can assume that standard policies, such as those recommended in the Hastings Center's *Guidelines on the Termination of Life-Sustaining Treatment*, will lead decision makers through the thickets of the moral options. A revised and updated version of these guidelines, currently being compiled, should provide further assistance with these newer, more nuanced issues.

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## **HEC Forum**

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Volume 20, Number 2  
June 2008

### **Overcoming the Organ Shortage: Failing Means and Radical Reform**

*T. D. Harter*

With approximately one hundred thousand persons in the United States currently on organ transplant waiting lists, but only about ten- to twenty-thousand organ donations per year, addressing the organ shortage seems to require looking to alternative solutions. In this paper, the author argues for mandatory cadaver organ procurement (MCOP) as the best way to resolve the organ shortage within the United States. After briefly considering the ethics of a legal organ market and the advantages of MCOP, he turns to address six primary concerns MCOP would raise: that it would override the autonomy of patients or surrogates, that it would be coercive, that it may cause some patients to be killed for their organs, that it would be too costly to be practical, that it ignores other seemingly more ethical treatment options for transplant patients; and that it appears insensitive to the emotional circumstances surrounding the deaths of some patients whose organs would be procured.

Volume 21, Number 2  
June 2009

### **The Ethics of Organ Salvaging on Deceased Persons**

*V. Gateau*

This paper analyzes the various modes of organ retrieval performed on deceased persons, both as they were initially conceived and as they are currently formulated. It first shows on which principles the modes of consent that were initially implemented by countries resorting to transplant rested, and it offers an analysis of the limits of these modes for the supply of organs. Second, it provides a critical review of the new solutions that have been suggested to compensate for the "chronic" shortage of organs with

which transplant teams are faced. Finally, it advocates a definite form of an “ethics of organ salvaging,” whose aim would not be to compensate for the shortage of organs (can it really be compensated for?), but rather to found current (and future) organ retrieval and transplant practices on fair information with regard to health and social issues raised by each solution. This information would then allow individuals to be genuinely involved in transplant-related social and personal choices.

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### Heythrop Journal

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Volume 50, Number 5  
September 2009

#### **The Mystery of God and the Suffering of Human Beings**

*R. W. Miller*

While much more can and should be said about the problem of special divine action and human suffering, the author suggests that the conclusion from the argument of the first and second parts of this paper sets the parameters for dealing with the theological issue of God’s intervening in particular instances (i.e., special divine action) to prevent human suffering. In other words, however one works out a theology of special divine action in relation to human suffering, one must recognize that God’s special divine action cannot be continuous like God’s elevation of the creature in the beatific vision. Thus God cannot prevent destructive suffering in every instance nor utterly alleviate the primordial suffering of the creature that results from her living outside union with God in the beatific vision.

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### **Journal of Law, Medicine and Ethics**

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Volume 37, Number 1  
Spring 2009

#### **Recent Developments in Health Law**

*C. Ang, P. Ang, J. Wolpin, and E. Baron*

The article discusses the validity of requiring girls and women aged eleven to twenty-six years seeking status as permanent resident to produce documentation that they have received the human papillomavirus (HPV) vaccine in the United States. It is said that there is no legislative or regulatory check on whether the requirement is necessary, reasonable, or proportionate. The authors said that the ACIP [Advisory Committee on Immunization Practices] needs to coordinate to ensure that they do not impose arbitrary and unjustified barriers to lawful immigration.

#### **Currents in Contemporary Ethics: HPV Vaccines, Privacy, and Public Health**

*H. Harrell*

The article discusses the implications of HPV vaccine mandates on privacy and public health in the United States. It is said that HPV vaccine mandates are behavior regulation in the sense that the mandates affect how individuals engage in sexual activity. According to the author, it is important to apply any lessons learned from the experience of HPV vaccine mandates to future public health regulations that affect behavior or behavioral decisions.

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**Journal of  
Medical Ethics**

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Volume 34, Number 7  
July 2008

**The Ethics of Non-Heart-Beating  
Donation: How New Technology  
Can Change the Ethical Landscape**

*K. Zeiler, E. Furberg,  
G. Tufveson, and S. Welin*

The global shortage of organs for transplantation and the development of new and better medical technologies for organ preservation have resulted in a renewed interest in non-heart-beating donation (NHBD). This article discusses ethical questions related to controlled and uncontrolled NHBD. It argues that certain preparative measures, such as giving anticoagulants, should be acceptable before patients are dead but when they have passed a point where further curative treatment is futile, they are in the process of dying, and they are unconscious. Furthermore, the article discusses consequences of technological developments based on improvement of a chest compression apparatus used today to make mechanical heart resuscitation. Such technological development can be used to transform cases of non-controlled NHBD to controlled NHBD. In the authors' view, this is a step forward, since the ethical difficulties related to controlled NHBD are easier to solve than those related to non-controlled NHBD. However, such technological developments also evoke other ethical questions.

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**Kennedy Institute  
of Ethics Journal**

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Volume 35, Number 5  
May 2009

**Erring on the Side of Life:  
The Case of Terri Schiavo**

*D. Merrell*

In debates over life and death it is often said that one should err on the side of caution—that is, on the side of life. In the light of the recent case of Terri Schiavo, it is explained how the “err-on-the-side-of-life” argument proceeds, and an objection to it is offered.

Volume 19, Number 2  
June 2009

**Kantian Condemnation of  
Commerce in Organs**

*S.J. Kerstein*

Opponents of commerce in organs sometimes appeal to Kant's Formula of Humanity to justify their position. Kant implies that anyone who sells an integral part of his body violates this principle and thereby acts wrongly. Although appeals to Kant's Formula are apt, they are less helpful than they might be because they invoke the necessity of respecting the dignity of ends in themselves without specifying in detail what dignity is or what it means to respect it, and they cite the wrongness of an agent's treating another merely as a means without clarifying conditions under which this occurs. This paper crystallizes two different approaches to the Formula of Humanity and probes when ... the principle would imply that it is wrong to engage in “live donor” transactions, in which someone chooses to undergo a kidney extraction in exchange for money.

**The Incoherence of Determining  
Death by Neurological Criteria:  
A Commentary on *Controversies in the  
Determination of Death*, a White Paper  
by the President's Council on Bioethics**

*F. G. Miller and R. D. Truog*

Traditionally the cessation of breathing and heartbeat has marked the passage from life to death. Shortly after death was determined, the body became a cold corpse, suitable for burial or cremation. Two technological changes in the second half of the twentieth century prompted calls for a new, or at least expanded, definition of death: the development of intensive care medicine, especially the use of mechanical ventilators, and the advent of successful transplantation of vital organs. Patients with profound neurological damage, incapable of breathing on their own and in an irreversible coma, could be maintained for some period of time with the aid of mechanical ventilation. The situation of these patients posed two ethical questions. Is it appropriate to stop life-sustaining treatment? If so, is it acceptable to retrieve vital organs for transplantation to save the lives of others before stopping treatment? In 1968, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death proposed that death could be determined on the basis of neurological criteria, thus providing a positive answer to these two questions. According to the position of this committee, patients diagnosed with the cessation of brain function are

dead, despite the fact that they breathe and circulate blood with the aid of mechanical ventilation.

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**Medicine, Health Care,  
and Philosophy**

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Volume 12, Number 2  
May 2009

**Should or Should Not Forensic  
Psychiatrists Think about Free Will?**

*G. Meynen*

The forensic psychiatrist's task is often considered to be tightly connected to the concept of free will. Yet there is also a lack of clarity about the role of the concept of free will in forensic psychiatry. Recently, [S.J.] Morse [2007] has argued that forensic psychiatrists should not mention free will in their reports or testimonies, and, moreover, that they should not even think about free will. Starting from a discussion on Morse's claims, the author develops his own view on how forensic psychiatrists are confronted with the issue of free will and how they should deal with this concept and the confusion surrounding it. The author concludes that psychiatrists should at least feel free to think about free will and that the conceptual challenges connected to the issues of free will and accountability could rather encourage than deter forensic psychiatrists to think about them.