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- From the Director...
- Ethical Implications Of Embryonic Stem Cell Research
- Patient Authorization Cannot Justify Physician-Assisted Suicide
- Is Non-Heart-Beating Organ Donation Too Aggressive?

More information on how to subscribe to Health Care Ethics USA.

Review the Health Care Ethics USA Index of Past Publications.
I am delighted to initiate with this issue the electronic version of *Health Care Ethics USA*. The printed version of this quarterly journal had a national distribution, including its dissemination via our two partners in health care, Ascension Health and Catholic Health Initiatives. We hope that you find our electronic version of the journal to be more practical for your multiple uses in ethics committees etc. There were two main reasons for the Center to move from a printed version to an electronic version of the journal. Most importantly, in the e-culture of modern health care we would like the journal to be available as widely as possible with a flexibility of use that the printed version could not offer. The second reason was fiscal stewardship - the printing costs for the journal have escalated so that the only way of continuing would be to more than triple the annual subscription. Instead, we can retain the current subscription rate and provide a more extensive service to the ministry via the electronic distribution of the journal. A letter has been sent to each subscriber explaining how to access the journal electronically. So welcome aboard to this new format of our e-journal! Please let us know what you think; any suggestions to improve the format will be most welcome.

Another new item for your attention - in November we offer for the first time our newly designed three-day Institute on "Medical Ethics in Catholic Health Care: Living Our Values in the Clinical Environment" (November 9-11). At the Institute we will address many front-burner issues including the patient bill of rights, medical errors, internet medicine, genetics and transplants (including the controversial issue of embryonic stem cell research) and issues on death and dying. At the end of this e-journal you will find further information with a hot link to our web page for the full schedule, registration, etc.

As usual, to accommodate the hectic pace that drives the daily work of health care, participants are welcome to join us for one day, two days, or three days as schedules permit. We are looking forward to a very exciting new Institute and I encourage you to spread the word to colleagues who may be interested in participating.

This Fall semester we are very fortunate to have a prominent visiting scholar at the Center who brings an immense amount of experience in Catholic health care - Sister Marie Damian Glatt, who was President from 1992 until 1999 of the Sisters of Charity of Leavenworth Health Services Corporation based in Leavenworth Kansas. She offers us a wonderful opportunity to learn from the valuable insights she has gained as President of this large health system that stretches from the mid-west to the west coast. Sister Marie Damian has an office with us that provides her easy access to our libraries and research databases. We welcome her each day to our community of scholars, faculty and students alike, at the Center. By providing an academic haven from the hectic world she has known for many years we hope that she will contribute substantively to the development of the Center's new initiative in organizational ethics in health care. Moreover, she will be teaching our students in our academic colloquium series that we host each semester. Her topic for these colloquia is, “Governance and Sponsorship in Catholic Health Care”. If anyone in the region is interested in participating in this series please contact me for the schedule.

As usual, this issue has an essay on organizational ethics, on medical ethics, and on a foundational issue in health care. To begin, I present an essay on the ethical implications of embryonic stem cell research, discussing the topic from the perspective of organizational ethics. I discuss the impact of new stem cell therapies that are derived from human embryos destroyed in the process. The second essay addresses an important topic of continuing interest in medical ethics - transplants. In this essay Jim DuBois discusses ethical questions that arise from recent developments in "non-heart-beating donation". The last essay by Jill Ciesla considers a foundational issue in health care by discussing physician assisted suicide from the perspective of patient authorization and consent. I hope you enjoy
these essays and I look forward to hearing from you about the new e-journal format of *Health Care Ethics USA*.

Gerard Magill, Ph.D.
Ethical Implications Of Embryonic Stem Cell Research

On August 23, 2000, the National Institutes of Health (NIH) announced new guidelines (effective on August 25) to permit stem cell research derived from human embryos. This astounding decision raises serious concerns in the foundational, medical, and organizational aspects of health care ethics. At the levels of foundational ethics and of medical ethics, the NIH decision constitutes an unfortunate assault on human life that pursues medical therapies for patients with disease or disability at the price of destroying or discarding human embryos. The reaction of the Vatican and the U.S. Bishops has focused upon this basic problem. This essay develops the concerns in foundational and medical ethics by examining the NIH decision from the perspective of organizational ethics - what is the impact of the NIH guidelines upon the delivery of Catholic health care in the United States? On the surface there may appear to be little immediate impact insofar as Catholic health care will not become involved with embryonic stem cell research. But closer scrutiny suggests that Catholic health care will have great difficulty avoiding the issue when stem cell therapies emerge. Unlike other ethical quandaries about human life, such as abortion, it will be much more difficult for us in Catholic health care to keep clean hands with regard to stem cell therapies. After all, by avoiding abortion we simply decline one service. But what will happen if we decline using an array of stem cell therapies that may stretch across the continuum of care, from neurological diseases to cancers to transplants? And if we opt not to use these new therapies when they are developed, will others in the secular or the for-profit arena have such a competitive edge on us that Catholic health care will no longer be financially viable? Simply, the NIH guidelines have far-reaching consequences for the continuance of Catholic health care -- especially when it seems likely that clinical trials on stem cell therapies might begin within 3-5 years time.

Principles

The really tricky dilemma, then, that is raised by the NIH guidelines is not whether Catholic health care should pursue embryonic stem cell research -- of course we cannot do so because of our respect for the human embryo. Rather, the dilemma is whether Catholic health care may avail itself of the stem cell therapies that are very likely to emerge from this research, especially if those therapies so permeate clinical practice that Catholic health care could not compete effectively without using them. There is an important principle in ethics that may shed light on this unfortunate scenario -- the principle of cooperation. This principle forbids formal cooperation that entails intending the wrongdoing of others (such as the destruction of human embryos after harvesting embryonic stem cells). But the principle can permit material cooperation with the wrong doing of others in circumstances that genuinely limit our moral freedom. Could the use of stem cell therapies by Catholic health care be justified by appeal to the principle of material cooperation? To address this question properly it is important to grasp the significance of stem cell research in modern medicine.

Discussion

In 1998, U.S. scientists found the method to isolate and culture embryonic stem cells. Using the technique of somatic cell nuclear transfer that was pioneered by the Roslin Institute in Scotland to clone the renowned ewe Dolly (in 1997), scientists in a laboratory at the University of Wisconsin-Madison isolated and cultured human embryonic stem cells for the first time. Then, during summer 2000, another team of U.S. scientists announced some success with adult bone marrow stem cells. The advantage of stem cells is that they have the versatility to be reprogrammed to grow other kinds of bodily organ or tissue. If stem cell research facilitates organ regeneration we might significantly decrease the annual death rate of nearly 4,000 patients awaiting transplants in the U.S. And stem cell therapies might include growing neurons to replace nerve cells in the brain or nurturing pancreatic cells to produce insulin for diabetics. These therapies may cater for conditions far beyond our reach today: Alzheimer's, Parkinson's, multiple sclerosis, spinal cord injuries, and many cancers. Of course, it is honorable for science to enhance the human condition in this way. However, ethics must ask
science to consider the means used to accomplish its end of benefiting humanity - ethics forces us to question whether we ought to pursue the benefits and therapies of stem cell research that may save human lives by means that destroy human embryos?

The NIH guidelines permit federal support, with taxpayer funds, for research on stem cells from human embryos that are unavoidably destroyed in the process of harvesting the cells. These guidelines seem to evade the spirit of a Congressional ban on this matter. Since 1996, Congress in its Appropriations Bill for the Department of Health and Human Services has forbidden the use of federal funds for research in which "embryos are destroyed, discarded or knowingly subjected to risk or injury." Technically, the NIH guidelines do not violate this prohibition because the agency's researchers will not extract the stem cells. That is, NIH researchers must obtain these stem cells only from other agencies, typically via private companies that extract the stem cells from aborted fetal tissue or from frozen embryos earmarked for destruction in fertility clinics. This stance by the NIH appears to be calling upon the principle of cooperation. That is, the NIH tries to create a distance between other agencies that harvest the stem cells from embryos and the use of the stem cells by NIH funded researchers. Indeed the principle applies here - but only as formal cooperation. It is very difficult to argue that researchers on embryonic stem cells are not morally complicit with the destruction of the embryo from which the cells were harvested. The question that Catholic health needs to ask is whether its future use of stem cell therapies derived from this research also would be morally complicit with the wrongdoing of destroying human embryos.

Another case that seems similar to this situation may shed some light. Several decades ago, cells derived from aborted fetal tissue were used in the development of vaccines. The production of vaccines today, such as for hepatitis A, uses the cell line derived from the isolation of those original cells. Health care today can use these vaccinations by legitimately calling upon the principle of material cooperation. Because only the cell line is used today, not fetal tissue, the development of beneficial vaccines is sufficiently distant and distinct from the originating fetal cells as to avoid the charge of moral complicity with the original abortion. This situation is very different from the scenario that develops therapies from stem cells actually harvested from human embryos. Health care today, especially in the Catholic ministry, will need to be very attentive to the relation between stem cell therapies and the destruction of human embryos. Because of the dramatic problem that will arise from therapies developed from stem cells that required the destruction of human embryos, Catholic health care needs to adopt a proactive stance with regard to this new research. I suggest two immediate measures that we must pursue.

First, from the perspective of science, stem cell research can be an honorable undertaking. But we must pursue this research via avenues that do not raise the ethical quandary of destroying human embryos. For example, we can harvest cells from umbilical cord blood or human placentas -- scholarly reports suggest these are rich resources of stem cells; and we can continue to investigate resources for adult stem cells, such as bone marrow stem cells that replenish red and white blood cells daily. These stem cells may not be as versatile as embryonic cells. But by following the high road of ethics, biotechnology may make discoveries that we cannot yet imagine. If we do not seek we may not find alternative ways to harvest versatile stem cells without having to destroy human embryos.

Second, from the perspective of ethics, we must encourage a policy debate about using embryonic stem cells. What a pity if we short-circuit ethical discourse on stem cell research! Skirting this debate is destined at best to create friction between Congress and the NIH and at worst to widen the chasm between science and society. What a pity if these technological marvels proceed in the long shadow of ethical compromise! Developing stem cell therapies that entail destroying embryos is destined to further fragment the delivery of care by increasingly separating patients and providers on grounds of conscience. However, engaging a policy debate on stem cell research can help to bridge biotechnology and ethics. Each step we take on this bridge will determine the next. And, as one of the leading scientific nations, the steps we take and the direction we follow in the U.S. will influence many other nations. Already Britain is considering legislation to clone human embryos for stem cells -- who would have thought we would face this Brave New World scenario so soon! Britain's government announced it would propose legislation that would go beyond its current approval of using human embryos for stem cell research: the new legislation will permit cloning of human embryos for medical research while retaining the current ban against implantation to create babies. Previously, in 1990 Britain's "Human Fertilization and Embryology Act" permitted some targeted research on embryonic tissues obtained via aborted fetuses or spare embryos from in-vitro fertilization techniques. In August 2000, after Britain's Chief Medical Officer Liam Donaldson endorsed research on embryonic stem cells...
for tissue and organ regeneration, the government announced it would submit legislation to parliament in the next session. So, as we approach this new landscape of embryonic stem cell research, we hope that the U.S. can match its scientific preeminence with international leadership in ethics.

**Conclusion**

As we consider embryonic stem cell research from the perspective of organizational ethics, it is evident that stem cell therapies will pose a serious challenge to the continuance of Catholic health care within a few years time. If the principle of cooperation will not justify the use of stem cell therapies because they are complicit with the destruction of human embryos, then Catholic health care may find itself unable to compete in a delivery environment that uses such therapies across the continuum of care. Faced with this specter of the sudden demise of Catholic health care, now is the time to engage a policy debate on the NIH guidelines. If Catholic health care sits back considering federal funding for embryonic stem cell research as mostly a problem for scientists in other facilities, we could make a strategic mistake that may effectively unravel our entire ministry.


Gerard Magill, Ph.D.
Center Director & Department Chair

**Questions for Discussion**

1. Will the Catholic ministry be compromised in its delivery of care when stem cell therapies are developed from discarded human embryos?
2. Does the principle of cooperation permit Catholic health care to use therapies derived from embryonic stem cells?
3. How can Catholic health care advocate effectively on this issue of embryonic stem cell research?

**Suggested Readings**

Magill, G. "Stem Cell Controversy Shows the Need to Bridge Science and Ethics," *St. Louis Post-Dispatch*, commentary section, (Sunday September 3, 2000): B3.


Three years after the U.S. Supreme Court ruling against a constitutional right to physician-assisted suicide (PAS), legal and ethical debate about PAS continues. This fall voters will decide whether Maine will be the second state in the nation to legalize PAS. It is interesting that while the U.S. Supreme Court addressed some key differences between PAS and honoring patient refusals of life sustaining treatment, proponents of PAS continue to treat these differences as negligible. The issue is evaluated as though respect for patient autonomy ought to be our primary concern.

An editorial of Tom Beauchamp, renowned for co-developing the most influential ethical approach among medical ethicists, manifests this autonomy-centered analysis of PAS. Describing contemporary trends in bioethical viewpoints, he claims that our new conception of the role of patient autonomy has moved us from "a fear of any form of intentional hastening of death to a confidence that it is permissible under a variety of conditions intentionally to forgo life-sustaining technologies of all types, knowing that death will ensue." According to Beauchamp, this confidence implies an acceptance of passive euthanasia and we are now moving toward respecting patient wishes with regard to requests for aid in dying, that is, assisted suicide. Beauchamp finds it appropriate that we make this move. He claims that the distinction between killing and letting die is not morally decisive, for there are generally accepted forms of killing such as killing in self-defense. Whether an act that ends in death is morally legitimate depends rather upon "features of particular circumstances," and in the health care setting the most relevant feature is whether the patient or proxy properly authorizes the act.

Interestingly, while pushing the thesis that "authorization" is the decisive morally relevant factor, Beauchamp still wants to use the terms "killing" and "letting die" to indicate what he views as a distinction between morally legitimate and morally illegitimate acts. However, he rejects the thesis that when an underlying disease or injury causes death, the agent who allows this death to occur does not kill but lets a patient die. For Beauchamp, when removing medical technology is not authorized by the patient or proxy, and the patient dies, the removal is an instance of killing. When removing medical technology is validly authorized by the patient or proxy, the removal is an instance of letting die. Beauchamp holds that instances of letting die include deaths that, according to him, are caused not by any underlying condition or disease but by another factor. "Removing a nasogastric tube to abate hydration or nutrition," he claims, "leads to death from malnutrition, not death from an underlying condition of disease or injury." Nevertheless, with a valid refusal of the tube, the act is a case of justified (even obligatory) letting die.

With regard to PAS, Beauchamp on the one hand claims that the distinction between legitimate and illegitimate cases of causing death is irrelevant. Prescribing a lethal medication neither kills the patient nor lets the patient die. On the other hand, he argues that the role of authorization plays the same role in justifying PAS or euthanasia as it does in justifying withholding or withdrawing treatment. There is no moral wrong in meeting a person's request for death provided the person "freely elects and authorizes death and sees that event as a personal benefit." In both refusing life-sustaining treatment and in requesting assistance in dying, persons are simply selecting different "means to the end of quitting life."

In this essay I want to clarify why Beauchamp's claims are inadequate. They rest upon an exaggerated notion of autonomy, and overlook significant differences between types of acts.

**Principles**

Aiming to support his claim that it is morally irrelevant whether or not a health professional causes death, Beauchamp points to forms of killing that are generally considered acceptable, such as killing in self-defense. What he fails to consider, however, is that the generally accepted justifications of killing do not include killing innocent persons or persons who pose no serious threat to others. While persons
have the right not to be treated against their will, this does not imply that they have the authority to
directly attack their lives, that is, to initiate a fatal process, either with or without the aid of a health
professional. The longstanding moral prohibition against suicide and killing innocent human beings is
supported by factors that Beauchamp does not consider, such as the limits of human dominion. Is it
not hubris for persons to assume that they are the absolute masters of their lives and may end their
lives when they will? The proper stewardship we ought to exercise over our lives normally does not
oblige us to use means that involve any grave burden to ourselves or others.¹ But forgoing heroic
measures is different from directly attacking human life. A further consideration is the consequences
for a society that accepts the practice of health professionals killing their patients or helping them to kill
themselves. Will this not damage the respect for life essential for a flourishing society and damage the
trust essential to the relationship between patients and health professionals?²

With these considerations in mind, the distinction between acts that cause death and acts that allow
persons to die of underlying conditions is morally significant. Beauchamp fails adequately to
acknowledge the difference between these types of acts. He implies that when one removes a
nasogastric tube from a person dependent upon it for nutrition and hydration, the ensuing death is
from malnutrition and not from an underlying disease or injury. However, if an underlying condition
prevents normal assimilation of nutrition and hydration (that is, assimilation of nutrition and hydration
without a nasogastric tube), removal of the nasogastric tube leads to death from malnutrition and from
an underlying condition. An analogous relation between cause and effect is present in the case of a
person with myopia who misplaces her glasses (her “sight-sustaining treatment”) and so suffers for a
time from poor vision. The misplacing of her glasses may be said to lead to her poor vision, but her
poor vision is not strictly caused by the misplacing of her glasses but by her myopia. Similarly, while
one cannot deny that removing the nasogastric tube leads to malnutrition, it would be erroneous to
claim that the underlying condition plays no causal role in the ensuing malnutrition.

Of course, the fact that a person has an underlying disease or injury that, without treatment, will cause
death, does not in itself justify withholding or withdrawing treatment. In many cases it would be morally
unjustifiable to let another fatal cause, whether in oneself or in another, produce its natural effect.
Persons who wrongfully remove life-sustaining treatment are indeed morally culpable for the resulting
deaths, but their acts are not acts of killing, for removing treatment does not in and of itself attack life.
In contrast, persons who administer a lethal injection to another person or to oneself not only perform
acts that lead to death; they kill. They directly attack life, initiating a fatal process or event rather than
allowing an already existing fatal condition to run its course. Whereas letting die is sometimes
permissible, intending to kill an innocent person is never permissible.

Discussion

Beauchamp’s failure to admit a distinction between killing and letting die is partly based on a mistaken
idea about intentions. While the remote intentions (that is, the reasons one has for performing a
certain act) play an important role in determining an act’s moral character, they do not change the type
of act one performs. Thus, even when (as in Beauchamp’s example) one’s intention in removing a
nasogastric tube is “to abate hydration and nutrition” so that the person will die (a bad intention), one
performs an act of letting die rather than of killing. On the other hand, if one administers a lethal
injection, even with the intention that the person through death will be free from suffering, one
performs an act of killing.

Not only does Beauchamp fail sufficiently to distinguish between types of acts. He also fails to see
how persons can have very different intentions in cases of letting die. He wrongly assumes that the
intentional forgoing of life-sustaining technologies implies an intentional hastening of death, and is
passive euthanasia. However, provided that one does not directly kill oneself or another person,
performing an act that knowingly leads to a death need not at all entail an intention to hasten death.
For example, in deciding to forgo life-sustaining technology that imposes an excessive burden on
oneself, one may intend to be relieved of the burdensome technology, being quite willing to try less
burdensome life-sustaining measures were any available. In such a case one would not be intending
to hasten death. Similarly, health professionals who remove life-sustaining technology may do so
simply for the sake of respecting the right of patients not to be treated against their will, and with no
intention to hasten their deaths. In contrast, intentionally to provide patients with an agent that works
strictly to initiate a fatal process necessarily entails an intention to hasten their deaths.

Conclusion
Persons are not obligated to sustain their lives by overly burdensome measures, and it lies beyond the dominion of health professionals to treat persons against their will. Still, respecting patient wishes to forgo life-saving treatment ought not to be interpreted as respecting a patient's authority to quit life. Such authority is not given to human persons, and thus it remains significant to distinguish between killing and letting die when comparing physician-assisted suicide with other acts that lead to death.


Jill E. Ciesla, M.A

**Questions for Discussion**

1. How convincing do you find the above distinction between killing and letting die?
2. What factors determine whether or not it is appropriate to honor a patient's request?
3. What factors make it morally justifiable to withhold or to withdraw life-sustaining treatment?

**Suggested Readings**


R.A. McCormick, "Vive la difference! Killing and Allowing to Die," *America* 177, no. 18 (6 December 1997): 6-12
Is Non-Heart-Beating Organ Donation Too Aggressive?

Health care and government leaders are constantly seeking ways to increase the number of organs donated for transplantation. Nevertheless, it is commonly feared that some strategies for increasing the donor pool might actually reduce the number of organs donated, because they might harm public trust in the transplant community. Thus, supporters and critics of organ donation alike worry when organ procurement policies appear too "aggressive." Policies are deemed too aggressive when they seem to emphasize increasing the donor pool without sufficiently considering safeguards to organ donors. The US has already considered and rejected several organ donation policies because they appear to do just this. For example, even though some European nations have increased donation rates by implementing "presumed consent" policies, in the US we have avoided such policies in order to better protect the donor's right to provide informed consent. Similarly, while some have argued that "financial incentives" might increase organ donation, we have resisted such policies because they risk coercing the poor and "commodifying" donor bodies.

Principles

This year, the Institute of Medicine reiterated its support for non-heart-beating donation (NHBD).\(^1\) Non-heart-beating donation differs from traditional organ donation in that the organ donor is declared dead using circulatory-respiratory criteria, rather than brain-death criteria. A typical scenario involves a comatose, ventilator-dependent patient whose proxy has decided to discontinue life support because such treatment is either overly burdensome or fails to meet the patient's therapeutic goals. The ventilator is removed, death is declared a few minutes after cardiac arrest, and organ procurement begins almost immediately thereafter. Non-heart-beating donation presents us with many ethical issues. This essay will address only three issues - issues related to the charge that it is too aggressive. Specifically, some have charged that in the interest of procuring more organs, NHBD protocols are being implemented which risk the following: (1) permitting organ procurement to begin before the donor is really dead; (2) hastening the death of the donor by using anticoagulants prior to death; and (3) creating an environment that alienates families from patients at the very end of life.

To address these three concerns, it is necessary to consider three ethical principles in the context of our discussion: (1) respecting life, (2) the principle of double effect, and (3) fostering family involvement.

Discussion

1. Are Non-Heart-Beating Donors Really Dead When Procurement Begins? The principle of respecting life is embodied in legal and ethical norms against homicide. These norms dictate that organ donors must not be killed in the process of donating organs. For this reason, both brain-death and NHBD organ donation protocols require that patients be declared dead before organ procurement begins. Nevertheless, some fear that the declaration of death in NHBD protocols is premature. There are two reasons why people have alleged this. Both reasons relate to the Uniform Determination of Death Act (UDDA). The UDDA states that death may be declared when the individual sustains "either (1) irreversible cessation of circulatory and respiratory function, or (2) irreversible cessation of all functions of the entire brain, including the brain stem."

The first reason why some allege that the declaration of the death is premature in NHBD protocols is that we would have to wait at least 9-10 minutes after circulation is lost in order to ensure that the patient meets brain death criteria. However, this approach to declaring death is based on a mistaken reading of the UDDA. NHBD protocols use circulatory-respiratory criteria, not neurological criteria, to declare death. Our laws permit death to be declared using either set of criteria; they do not require the use of both criteria. This bifurcated approach to declaring death is nevertheless consistent with the fact that death is just one, unified phenomenon: with the loss of circulation and respiration, integrated unity is lost, the brain shuts down and consciousness is lost within seconds. Moreover, brain functions will
never again be restored (unless circulation and respiration are restored).

The second reason why some object to the declaration of death recommended in NHBD protocols stems from the UDDA's circulatory-respiratory criteria. Specifically, the UDDA requires that the loss of circulation and respiration be irreversible. Some have argued that NHBD protocol cannot possibly satisfy this requirement, because with aggressive CPR the heart might regain circulatory function even after it has arrested for 2-5 minutes. So how is it that the Institute of Medicine has recommended the use of NHBD protocols? First, all evidence to-date suggests that by waiting one or two minutes after the loss of cardiac function we can safely rule out autoresuscitation. Second, all NHBD protocols require that the patient or his or her proxy has made a valid decision to withdraw treatment and to declare the patient DNR. Thus, it would be illegal and unethical to resuscitate such patients. Given these facts, when the patient is declared dead using NHBD criteria, we do know that circulatory and respiratory functions have been irreversibly lost.

2. Is Death Intentionally Hastened? NHBD protocols often recommend that a large dose of Heparin or a similar anticoagulant be administered in order to prevent blood clotting and to permit a better "flush" of organs after they have been procured. This is an important step in preserving organs so that they remain suitable for transplantation. However, many of the patients who become donors using NHBD protocols are severely head injured. Thus, the use of anti-coagulants is typically contraindicated, because there is a risk that the brain might hemorrhage. Using Heparin thus risks hastening the death of the donor (though the actual extent of the risk is unknown).

Is the use of Heparin before death unethical? Certainly, the intention in using Heparin is good, not evil: it is meant simply to aid the preservation of organ for transplantation, not to hasten death. Thus, it might be that the principle of double effect can be invoked: the risk of a negative effect is foreseen, but it is not intended. However, the proper use of the principle of double effect requires that other criteria be met as well. In this case, it is fair to say that the risk of causing death is not a means of achieving the good that is aimed at (i.e., thinning the blood). It is also fair to say that the risk is likely proportionate to the good at stake for the simple reason that it is assumed that the patient is in the process of dying after the ventilator has been removed. The biggest challenge in applying the principle of double effect is the following: ordinarily, the person who endures the foreseen negative effect also benefits from the intended positive effects. In this case, it would seem that the organ recipient is the primary beneficiary.

However, in many cases it would be wrong to deny that organ donation also benefits the organ donor. We often speak of organ donation as a way of providing a "gift of life" and many people find this deeply meaningful. Many donor families experience organ donation as healing, as a way of finding meaning in what sometimes appears to be a meaningless tragedy. If this is true, then it would seem that - if consent is properly given - organ donation can be viewed as a good also for the donor, and the principle of double effect might be applied legitimately.

Not everyone accepts this line of argumentation. But fortunately, refusing to use Heparin in cases in which it is normally contraindicated need not be devastating to the use of NHBD protocols. First, the Institute of Medicine actually recommends that the decision whether to use Heparin should be made on a case-by-case basis. (It also rightly recommends that consent be obtained for the use of any medications that are not directly of benefit to the donor). Second, some organ procurement organizations are currently experimenting with the administration of Heparin post-mortem, and perhaps time will show that these organs too are suitable for transplantation.

3. Does NHBD Alienate Families From Dying Patients? Because organ procurement must begin shortly after death is declared, from a medical point of view, the best place to withdraw ventilation and to declare death is in the operating room. This is not the environment that most people would choose to die in. Moreover, because death is followed by procurement surgery, families are encouraged to leave the room soon after death is declared. With these facts in mind, some have charged that NHBD alienates families from dying patients and that it provides an inhumane context for death.

Some protocols address these concerns by declaring death in a room near the OR, rather than in the OR. They also invite families to remain with the patient until death is declared. Nevertheless, it cannot be denied that NHBD does not provide an ideal setting for death. But two things must be borne in mind. NHBD only occurs when a decision has been made to remove ventilation from a critically ill patient. Such scenarios already deviate from the ideals of dying peacefully in one's sleep or (especially in the case of comatose patients) of dying at home after making one's peace with family and God.


Secondly, donation is often instigated by donor families. As mentioned above, donation is typically not perceived by families as a tragedy added onto a tragedy, but as a way of finding meaning in tragedy.

Conclusion

Non-heart-beating organ donation presents a number of ethical challenges. This essay did not address the need to avoid conflicts of interest, the need to protect the interests of organ recipients, or the process of developing protocols. However, it has attempted to show that NHBD protocols are not desperate attempts to increase the number of organs for transplantation at the expense of organ donors. Well-designed NHBD protocols protect donor interests while enabling them to make a life-prolonging gift at the very end of their own life.


James M. DuBois, Ph.D., D.Sc.

Questions for Discussion

1. Is it consistent to provide two criteria for determining death when death is one, unified phenomenon?
2. Is it reasonable to think that donating organs can sometimes be good for the organ donor or donor family, as well as for the organ recipient?
3. What should the informed consent process involve in NHBD?

Suggested Readings