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Brain Death and Organ Removal: Revisiting a High-Stakes Question[1]

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The irreversible cessation of all brain activity as a criterion for death, including that of the brain stem, was suggested in 1968 by the now famous report of an ad hoc committee at Harvard Medical School. For several years now, this criterion has once again been the object of rather well-publicized critical reflection, chiefly in the Anglo-Saxon world and, more recently, in the German-speaking world. The German philosopher Ralf Stoecker has even gone so far as to assert, during his March 21, 2012, speech to the German Ethical Council (*Deutscher Ethikrat*): "To my knowledge there is no convincing argument for the validity of the concept of brain death, today even less than in 1997,"[2] the year in which Germany authorized the removal of organs from a human being whose death had been certified according to this cerebral criterion. In opposition to those who say that medical science has succeeded in proving the appropriateness of the brain-death criterion, he concluded that "recourse to the concept of brain death today, moreover, is no longer sufficient to determine whether or not it is permissible to remove organs."[3] He

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[1] My special thanks to my wife Michele M. Schumacher for her very insightful comments and to Michael J. Miller for his translation.

[2] Ralf Stoecker, "Der Hirntod aus ethischer Sicht," last accessed, August 2, 2016, http://www.ethikrat.org/dateien/pdf/fb-21-03-2012-stoecker-referat.pdf: "Es gibt meines Wissens kein überzeugendes Argument für die Gültigkeit der Hirntod-Konzeption, heute noch weniger als 1997."

[3] Ibid.: "Der Rückgriff auf die Hirntod-Konzeption heute ohnehin nicht mehr

therefore considers the debate about brain death "useless."[4]

His position is not an isolated case. It is along the same lines as the stance taken by a number of Anglo-Saxon physicians, legal scholars, and philosophers who have expressed serious doubts as to the legitimacy of the brain-death criterion. "No plausible and coherent account has been advanced to explain why brain-dead patients are dead,"[5] the American bioethicist Franklin G. Miller had explained three years earlier, following his colleague Robert D. Truog, who thinks that "the concept of brain death is seriously problematic."[6] The American philosopher Don Marquis ratchets up the rhetoric: "The orthodox legal definition of death is indefensible."[7] Brain death is likewise described by the American bioethicist Robert M. Veatch as being "old-fashioned" and "less and less plausible,"[8] all the more so because, as the American physician Ari Joffe notes, "When one examines the rationale for BD being death itself, it is surprisingly hard to justify."[9]

This school of thought denounces the fact that the brain-death criterion was implemented in order to correspond to actual praxis. It is said to be, in the final analysis, a "legal fiction"[10] or "convenient"[11]

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ausreicht, um die Zulässigkeit von Organentnahmen zu klären."

4 Ralf Stoecker, "Der Tod als Voraussetzung der Organspende?" *Zeitschrift für medizinische Ethik* 58.2 (2012): 99–116, at 113: "fruchtlosen."

5 Franklin G. Miller, "Death and Organ Donation: Back to the Future," *Journal of Medical Ethics* 35.10 (2009): 616–20, at 619.

6 Robert D. Truog, "Brain Death–Too Flawed to Endure, Too Ingrained to Abandon," *Journal of Law, Medicine & Ethics* 35.2 (2007): 273–81, at 280.

7 Don Marquis, "Abortion and the Beginning and End of Human Life," *Journal of Law, Medicine & Ethics* (Spring 2006): 16–25, at 21.

8 Robert M. Veatch, *Transplantation Ethics* (Washington, DC: Georgetown University Press, 2000), 139.

9 Ari Joffe, "Are Recent Defenses of the Brain Death Concept Adequate?" *Bioethics* 24.2 (2010): 47–53, at 47.

10 See Seema K. Shah and Franklin G. Miller, "Can we handle the Truth?" *American Journal of Law and Medicine* 36.4 (2010): 540–85, at 542: "Instead, the determination of death has been modified to fit our current practices, thereby creating legal fictions. . . . invoking legal fictions about donors being dead [whole brain dead] when, in fact, they are alive or not known to be dead." See also Stuart J. Youngner and Robert M. Arnold , "Philosophical Debates About the Definition of Death: Who Cares?" *Journal of Medicine and Philosophy* 26.5 (2001): 527–37, at 535: "We no longer need the fiction of brain death to facilitate termination of treatment."

11 Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (New York: St. Martin's Press, 1994), 35.

along the lines of what the German philosopher Dieter Birnbacher very recently described as a psychological "strategy of suppression"[12] or, as the German legal scholar Wolfgang Höfling put it, an "illusory self-deception."[13] The American physician Robert Taylor points out the fact that we know perfectly well that persons who are declared brain dead are actually alive but that we want to consider them dead. The criterion of brain death, these thinkers say, is ultimately a societal construct and not a truth based on reason and science.[14]

These authors wish to break the taboo that surrounds any questioning of the brain-death criterion. The refusal to take into consideration even the hypothetical possibility of an error in this regard was illustrated by recent medical-ethical guidelines issued by the Swiss Academy of Medical Sciences (*Académie suisse des Sciences médicales*, or ASSM) with regard to the "Diagnosis of death in the context of organ transplantation."[15]

Why this silence and refusal even to reargue the legitimacy of the brain-death criterion? If we were to find that it was wrong (i.e.

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[12] Dieter Birnbacher, "Das Hirntodkriterium in der Krise—welche Todesdefinition ist angemessen?" in *Welchen Tod stirbt der Mensch? Philosophische Kontroversen zur Definition und Bedeutung des Todes*, ed. Andrea Esser, Daniel Kersting, and Christoph G. W. Schäfer (Frankfurt am Main: Campus, 2012), 19–40, at 36: "eine Verdrängungsstrategie."

[13] Wolfgang Höfling, "Tot oder lebendig—tertium non datur. Eine Verfassungsrechtliche Kritik der Hirntotkonzeption," *Zeitschrift für medizinische Ethik* 58.2 (2012): 163–72, at 169: "illusionäre Selbsttäuschung."

[14] Robert M. Taylor, "Reexamining the Definition and Criterion of Death," *Seminars in Neurology* 17 (1997): 265–70, at 269: "The whole-brain criteria of death is also a social construct, distinct from biological death, created to serve a utilitarian social purpose." See Marquis, "Abortion and the Beginning and End of Human Life," 23 : "Consider now a brain dead patient in whom, with ventilator support, respiratory and circulatory functions continue. Because she is still a (minimally) integrated biological organism, she is still alive. Because to remove her vital organs for transplantation is to kill her, bioethicists have endorsed bad arguments for the view that such individuals are dead, in order to justify transplantation." See also Alan D. Shewmon, "Brain Death: Can It Be Resuscitated?" *Hastings Center Report*, 39.2 (2009), 18–24, at 19.

[15] Académie Suisse des Sciences médicales, *Diagnostic de la mort dans le contexte de la transplantation d'organes: Directives medico-éthiques* (Muttenz, CH: Schwabe, July 2011). These guidelines were approved by the Senate of the ASSM on May 24, 2011. Although the bibliography mentions the famous report by the President's Council on Bioethics in the United States—*Controversies in the Determination of Death: A White Paper by the President's Council on Bioethics* (Washington, DC, December 2008)—which enters into the debate, the substance of this report is not analyzed at all.

illegitimate), people often say, it would have disastrous implications for the removal and transplantation of vital organs at a time when we see an ever-increasing shortage of donors. On the other hand, the continuation of this practice would be tantamount to approval of putting living persons to death and, in the final analysis, of using them only as means to an end for the benefit of other persons—or to quote the very telling image of the German philosopher Hans Jonas, approval of engaging in the "vivisection"[16] of a person under the best possible conditions so as to procure his organs and tissues.

Indeed, the removal of vital organs presupposes, as a general rule, the death of the person; it is based on the Dead Donor Rule. As the ASSM explains, "when organs are removed, what is being manipulated is the corpse of a deceased person,"[17] not a living human organism.

This principle is based on the moral principle that requires us to treat every human being in terms of Kant's second categorical imperative, as an end in himself and never merely as a means.[18] No price can be set on a human being. He transcends any attempt to exploit him, as is reaffirmed throughout *Human Dignity and Bioethics*, the recent report issued by the Bioethics Council at the request of the President of the United States. Hence he should not be killed in order to guarantee the wellbeing of other persons.

The recent report by the US President's Council on Bioethics on the topic of death, published in December 2008, takes up the current controversy surrounding the brain-death criterion. Here is what it says: "*If* indeed it is the case that there is no solid scientific or philosophical rationale for the current 'whole brain standard' then the only ethical course is to stop procuring organs from heart-beating

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16 Hans Jonas, "Philosophical Reflections on Experimenting with Human Subjects," in *Philosophical Essays: From Ancient Creed to Technological Man* (New York: Atropos Press, 2010), 107–33, at 131.

17 *Diagnostic de la mort*, 19: "lors du prélèvement d'organes, c'est le corps d'un défunt qui est manipulé."

18 See Emmanuel Kant, *Groundwork of the Metaphysic of Morals*, trans. H. J. Paton (New York: Harper and Row, 1964), 96: "Act in such a way that you always treat humanity whether in your onw person or in the person of any other, never simply as a means, but always at the same time as an end"; the German original can be found in *Grundlegung zur Metaphysik der Sitten* in *Gesammelte Schriften*, Königlichen Preussischen Akademie der Wissenschaften, 23 volumes (Berlin: Walter de Gruyter, 1902), 4:387–463, at 429: " Handle so, daß du die Menschheit, sowohl in deiner Person, als in der Person eines jeden andern, jederzeit zugleich als Zweck, niemals bloß als Mittel brauchest. "

individuals."[19] Is this argument justified? Should we not reframe the debate so as to situate it exclusively on the ethical level by abolishing the requirement of the Dead Donor Rule, as Stoecker and Birnbacher suggest, following Anglo-Saxon thinkers of the utilitarian school? Or, on the contrary, should we not admit that the question of the ethical legitimacy of removing vital organs is based, after all, on a philosophical anthropology, ultimately on a definition of human death, which would be accompanied by scientific/medical thinking to determine the criterion that would enable us to be certain about the moment when death occurs?

In order to determine more clearly what is currently at stake in the brain-death criterion associated with the removal of vital organs, I will present, in an initial section, very succinctly, the challenges to this criterion formulated particularly by those who defend the criterion of brain stem death and of neocortical death. (A third position, which I will not discuss here but which could be described as post-modern and relativistic, consists of letting each individual and each community freely choose the criterion of death that suits him or it best.) Then I will continue with what these positions imply with respect to the removal of vital organs. In my second section, I will develop a fourth position that is based mainly on the empirical study of cases of persons who are considered dead according to the brain-death criterion but who apparently continue to live; that is, they independently manifest an integral organic unity. I will discuss the validity of this new criterion of death based on the permanent cessation of circulatory and respiratory systems. Finally, citing the principle of precaution, whereby in a doubtful case one should decide in favor of the likelihood of the presence of a human life, I will study several consequences resulting from the removal and transplantation of organs. I will present first the arguments for shifting the debate from the anthropological and medical level to the ethical level exclusively, which involves abolishing the requirement of the Dead Donor Rule, thus making possible the removing of vital organs. However, this transfer to the ethical level paradoxically necessitates recourse to a certain anthropology. Distancing myself from such a position, I will suggest shifting the debate to the level of a discussion of therapeutic obstinacy (*obstination déraisonnable*), which accompanies the removal of organs in the particular situation of controlled cardiac arrest of persons who are considered brain dead.

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[19] *Controversies in the Determination of Death*, 12.

Criteria for Death Based on the Death of the Brain Stem and Neocortical Death

The brain-death criterion is based on the fact that the different parts of the brain (the brain stem, the neocortex, and the cerebellum) have stopped functioning irreversibly. Very swiftly, two camps formed that tried to call this criterion into question on the basis of a dualist anthropology. Their advocates presuppose a radical distinction between the human organism, on the one hand, and the human person, on the other.

Those in the first camp say that death is above all a biological phenomenon corresponding to the irreversible cessation of the interactive functioning of the organism understood as a unity.[20] Death occurs, therefore, when the brain stem definitively ceases to function by itself (brain stem death). This death occurs on the biological level only, not at all on the level of the spiritual faculties of the human being.

Those in the second camp define death as the irreversible loss of what is essential not to the organism but to the person. They make a fundamental distinction between "human being" and "person." As the American philosopher John Lizza puts it, "the criteria for the death of a person or human being will therefore be determined by the loss of whatever properties are deemed essential to the nature of persons or human beings."[21] This presupposes that a person is not defined by his corporeality but exclusively by the exercise of certain personal faculties, such as self-consciousness and reason, freedom and responsibility, and the ability to project oneself as a subject into the future and to express one's interests consciously. A person is then considered as deceased when he no longer exercises these personal faculties and this state is irreversible—in other words, when his neocortex is destroyed—even if his physical organism continues to live.

The American philosopher Jeff McMahan nicely summarizes this point of view. According to him, "it is entirely natural to say that a person dies when he ceases to exist [i.e., to have self- consciousness],

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[20] See, for example, Charles M. Culver and Bernard Gert, *Philosophy in Medicine* (Oxford, UK: Oxford University Press, 1982); Fred Feldman, *Confrontations with the Reaper: A Philosophical Study of the Nature and Value of Death* (Oxford, UK: Oxford University Press, 1992); and David Lamb, *Death, Brain Death and Ethics* (London: Croom Helm, 1985).

[21] John Lizza, *Persons, Humanity, and the Definition of Death* (Baltimore, MD: Johns Hopkins University Press, 2006), 32.

even if his organism remains alive."[22] Such an organism would be, to use an expression of the American bioethicist Tristram Engelhardt, a "biologically living corpse."[23]

What consequences can be drawn from this criterion of death based on a dualist anthropology that refers, in the final analysis, to a Lockean definition of the human person?[24] It would be permissible to remove organs from human organisms that were not or were no longer persons, for they would be considered dead on the personal level. This would mean not only anencephalic infants but also, Engelhardt emphasizes, "infants, the retarded, adults, and the senile,"[25] as well as a human being in an irreversible "vegetative" state. In fact, because such human beings do not—or no longer—exercise the so-called personal faculties, they are considered as being merely human organisms and not—or no longer—as persons. Furthermore, the Dead Donor Rule would be respected, since we would no longer be dealing with a living person. The reason underlying the introduction of this criterion of the death follows from utilitarian pragmatism (among other things), for we are talking here about a direct, economic method: "The simplest way of achieving the desirable end of allowing organs to be taken from these infants,"[26] the Australian philosopher Peter Singer emphasizes. Such statements go against common sense and are profoundly counterintuitive. Setting up a priori the veracity of a dualist anthropology that reduces the person to the actual exercise of a certain number of personal faculties, they introduce a fundamental inequality—which could even be called a

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[22] Jeff McMahan, *The Ethics of Killing* (Oxford, UK: Oxford University Press, 2002), 425. He also writes that, "If one ceases to be a person in this sense [i.e. ceases to exercise self-awareness and reason], he or she ceases to exist" (ibid., 45).

[23] H. Tristram Engelhardt, *The Foundations of Bioethics* (Oxford, UK: Oxford University Press, 1996), 248.

[24] The Lockean person is defined by the exercise of self-consciousness, without regard for any substance, whether corporal or spiritual, see John Locke, "Identity and Diversity, " in *An Essay Concerning Human Understanding*, bk. II, ch. 27 (Oxford, UK: Oxford University Press, 1979), 328–48. For a critique of this dualist anthropological position that is explicitly based on John Locke's definition of the person, see Bernard N. Schumacher, "La Personne comme conscience de soi performante au cœur du débat bioéthique: Analyse critique de la position de John Locke," *Laval théologique et philosophique* 64.3 (2008): 709–43.

[25] Engelhardt, *Foundations of Bioethics*, 250.

[26] Singer, *Rethinking Life and Death*, 47.

new racism—within the human family and end up justifying the exploitation of the human being by his peers in the name of a new criterion: the non-exercise of those faculties.

Death as Permanent Cessation of Circulatory-Respiratory Function

Another frontal attack against the brain-death criterion follows when one takes into account a number of cases examined empirically by the American physician Alan Shewmon. He noticed that some persons—fifteen years ago he had counted 175 of them—who were considered dead according to the brain-death criterion would continue to live. As of the time of the publication of his research, the duration of their lives after diagnosis ranged from one week to more than fifteen years. He observed that these persons continued to activate some bodily functions that he deemed to be of the integrating sort for the benefit of the organism's unity, thanks of course to the assistance of an artificial ventilator, but also of a feeding tube and nursing care. Among these functions are, in particular: (1) respiration (described by the American physician not as the circulation of air in and out of the lungs, which is the role assigned by the brain stem to the diaphragm, but as the metabolic exchange of oxygen and carbon dioxide, which proves to be more crucial to ensuring integrative unity), (2) nutrition (described by Shewmon not as something dependent on the mouth and pharynx as coordinated by the brain, but as the reduction of food into elementary forms that are burned to produce energy or assimilated into the structure of the body), (3) the heartbeat, (4) the circulation of blood, (5) digestion, (6) the maintenance of body temperature, (7) the ability to heal a wound, (8) defense against infections and foreign bodies, but also (9) the intrauterine life of a fetus and his or her birth. Moreover, healthcare professionals in intensive care units find that a large number of these persons who are brain dead sometimes require much less technological assistance, or even less care, than many sick or dying patients present in those same units. Furthermore, some persons who had been considered brain dead have left the hospital to go back home, where they receive from then on the care that they need.[27]

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[27] See Alan Shewmon, "'Brainstem Death', 'Brain Death' and Death: A Critical Re-Evaluation of the Purported Equivalence," *Issues in Law and Medicine* 14.2 (1998), 125–45, at 138–39, and his "Brain Death: Can It Be Resuscitated?" 19. Concerning the intrauterine life of a fetus and its birth, see Patrick Yeung, Christopher McManus, and Jean-Gilles Tchabo, "Extended Somatic Support for a Pregnant Women with Brain Death from Metastatic Malignant Mela-

Shewmon states that a human being is defined from an anthropological perspective as a holistic, integrative unity within which the nervous, hormonal, and immune systems do not have the brain as their center. Hence, in order to function, not all the organs depend on the brain, although certainly it does foster the optimal exercise of the various integrative organic systems. The American physician explains that "far from constituting a 'central integrator,' without which the body reduces to a mere bag of organs, the brain serves as modulator, fine-tuner, optimizer, enhancer, and protector of an implicitly *already existing intrinsically mediated* somatic unity. Integrative unity is *not* a top-down imposition from a 'central integrator' on an otherwise unintegrated collection of organs. . . . Rather, it is a *non-localized*, *holistic property* founded on the mutual interaction among all the parts of the body."[28] A patient who is dead according to the brain-death criterion but whose organism nevertheless exhibits the activity of a certain number of bodily functions is not properly speaking considered dead, but rather as very sick or possibly as dying.[29]

Taking into consideration these empirical cases and interpreting these bodily functions as integrative are defended by two groups that cite several definitions of the human persons. Asserting that every human being is fundamentally a human person, the first group declares that a person is not dead until the moment when "the circulatory, respiratory, and nervous systems (the three most important vital systems of the body) have been destroyed."[30] It is interesting to note that the second group is made up of a number of advocates of the

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noma: A Case Report," *Journal of Maternal-Fetal and Neonatal Medicine* 21.7 (2008), 509–11, and David J. Powner and Ira M. Bernstein, "Extended Somatic Support for Pregnant Women after Brain Death," *Critical Care Medicine* 31.4 (2003), 1241–49.

[28] Shewmon, "'Brainstem Death', 'Brain Death' and Death," 140.

[29] See Alan Shewmon, "The Brain and Somatic Integration: Insights into the Standard Biological Rationale for Equating 'Brain Death' with Death," *Journal of Medicine and Philosophy* 26.5 (2001): 457–78, at 464–72.

[30] Michael Potts, Paul A. Byrne, and Richard G. Nilges, "Introduction," in *Beyond Brain Death: The Case against Brain Based Criteria for Human Death* (Dordrecht: Kluwer Academic Press, 2000), 1–20, at 2–3. See also Michael Potts, "A Requiem for Whole Brain Death: A Response to D. Alan Shewmon's 'The Brain and Somatic Integration,'" *Journal of Medicine and Philosophy* 26.5 (2001), 479–91; Nicanor Pier Giorgio Austriaco, "In Defense of the Loss of Bodily Integrity as a Criterion for Death: A Response to the Radical Capacity Argument," *The Thomist* 73.4 (2009), 647–59; and *Finis Vitæ: Is "Brain Death" True Death?* ed. Roberto de Mattei and Paul A. Byrne (Oregon, OH: Life Guardian Foundation, 2009).

neocortical death criterion. The latter insist, however, on qualifying their position under the pretext of their anthropological dualism, saying that this alternate criterion of death applies only to the death of the human being, as characterized by his organism, and not at all to the death of the person. McMahan, for example, says that "brain death is neither necessary nor sufficient for the cessation of integrated functioning in the organism as a whole."[31]

Besides the arguments citing Shewmon's cases, one can moreover emphasize that the brain-death criterion implies that human life exists only when the brain is functioning. From this premise it follows that the human embryo would not be considered as a living individual until four to eight weeks after conception, but rather at most as an assemblage of various isolated organs.[32] It is commonly admitted, however, in the case of the embryo, that we have before us a particular living human being characterized (1) by an integrative function that is not regulated by the brain and (2) by the inability to breathe, as McMahan[33], Marquis[34], Shewmon[35] and even the embryologist Günter Rager agree in saying. The last-mentioned author explains that "the embryo directs its own vital functions autonomously from the zygote stage. It shows that it is a unified system capable of self-organization."[36] The embryo is more than a simple mass of cells because, from the moment of fertilization, it displays continuous development without quantum leaps. It "possesses the active potential of its further development. It will pursue that development by itself,

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[31] McMahan, *The Ethics of Killing*, 429; see also 434. See also David DeGrazia, *Human Identity and Bioethics* (Cambridge, UK: Cambridge University Press, 2005), 149.

[32] This is the argument proposed by Hans-Martin Sass in "The Moral Significance of Brain-Life Criteria," in *The Beginning of Human Life*, ed. Fritz K. Beller and Robert F. Weir (Dordrecht: Kluwer Academic Publishers, 1994), 57–70, at 63. See also Baruch Brody, *Abortion and the Sanctity of Human Life: A Philosophical View* (Cambridge, MA: MIT Press, 1976), 112.

[33] See McMahan, *The Ethics of Killing*, 437, and his "An Alternative to Brain Death," *Journal of Law, Medicine & Ethics*, 34.1 (2006), 44–48, at 46.

[34] See Marquis, "Abortion and the Beginning and End of Human Life," 19–20.

[35] See the position taken by Shewmon with respect to the Presidential Report *Controversies in the Determination of Death* in "Brain Death: Can It Be Resuscitated?" 20.

[36] Günter Rager, "Données biologiques et réflexions sur la personne," in *L'humain et la personne*, ed. François-Xavier Putallaz and Bernard N. Schumacher (Paris: Cerf, 2008), 97–114, at 100: "L'embryon dirige ses propres fonctions vitales, dès le stade du zygote, de façon autonome. Il montre qu'il est un système unifié capable d'auto-organisation."

without depending on someone else for it."[37] As for the German philosopher Birnbacher, he explains that:

> If one defines—with Michael Quante—the essential characteristic of life, understood biologically, as self-organization with the help of external resources, then the processes of self-organization that occur in the embryo and the fetus with the help of the mother's uterus are not substantially different from the processes of self-organization that occur in the body of a brain-dead person with the help of a mechanical ventilator. It would be contradictory to allow the organic life of the embryo and the fetus to be considered "genuine" life, but not the life of the brain-dead individual being artificially ventilated. Self-organization means that the parts of the organism work together in a coordinated way. This condition is likewise fulfilled in both cases. The process of self-organization in both cases depends on external resources for its maintenance.[38]

A third argument in favor of the thesis that a brain-dead human being is alive makes reference to the nervous system. As long as the nervous system is present in the tissues throughout the human organism, the latter can be considered living. Now, there is no nervous system in the embryo. One could nevertheless say that it is living

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[37] Ibid., 103: ". . .possède la potentialité active de son développement ultérieur. Il la poursuivra par lui-même, sans dépendre pour cela d'un autre."

[38] Birnbacher, "Das Hirntodkriterium in der Krise," 29–30: "Bestimmt man—mit Michael Quante—die wesentliche Eigenschaft des biologisch verstandenen Lebens als die Selbstorganisation unter Zuhilfenahme äußerer Ressourcen, unterscheiden sich die Prozesse der Selbstorganisation, die in Embryo und Fötus unter Zuhilfenahme des mütterlichen Uterus ablaufen, nicht wesentlich von den im Körper eines Hirntoten ablaufenden Prozessen der Selbstorganisation unter Zuhilfenahme eines Beatmungsgeräts. Es wäre widersprüchlich, das organismische Leben des Embryos und des Fötus als 'echtes' Leben gelten zu lassen, nicht aber das Leben des Hirntoten unter künstlicher Beatmung. Selbstorganisation bedeutet, dass die Teile des Organismus koordiniert zusammenwirken. Diese Bedingung ist in beiden Fällen gleichermaßen erfüllt. In beiden Fällen hängt der Prozess der Selbstorganisation zu seiner Aufrechterhaltung von äußeren Ressourcen ab." See also Birnbacher, " Der Hirntod—der Tod? " *Deutsche Zeitschrift für Philosophie* 60.3 (2012): 422–23, at 422, and "Der Hirntod—eine pragmatische Verteidigung," *Jahrbuch für Recht und Ethik* 16 (2007): 459–77, at 467–68. See also Michael Quante, *Personales Leben und menschlicher Tod: Personale Identität als Prinzip der biomedizinischen Ethik* (Frankfurt am Main: Suhrkamp, 2002), 69–70 and 152–53.

inasmuch as it has the capacity in its ontological structure, in its very nature, to generate such a system.

The presentation of Shewmon's cases and their interpretation has had a profound impact, not only on some proponents of the neocortical thesis but also, and more particularly, on the recent report of the US President's Council on Bioethics, *Controversies in the Determination of Death*. The members of this council acknowledge unequivocally that patients who have been diagnosed as having irreversibly lost all brain function but have a certain somatic integrity call into question the statement that their organism is nothing but a disordered collection of organs. Indeed, this report leaves no doubt about it: "If being alive as a biological organism requires being a whole that is more than the mere sum of its parts, then it would be difficult to deny that the body of a patient with total brain failure can still be alive, at least in some cases."[39]

The contributors to the presidential report, however, did not intend to adopt the position developed by Shewmon. Having opted instead for a shift in emphasis in the criterion for death, they suggest considering a person dead by referring no longer to the notion of integration and to the erroneous supposition that the brain integrates vital functions, but rather to the essential work of the living individual. Hence, death occurs when the body in its organic unity irreversibly ceases to perform its function or its duty—"the fundamental vital *work* of a living organism"[40]—in other words, when it is no longer capable of being open to the world and of acting to obtain what it

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[39] See President's Council on Bioethics in the United States, *Controversies in the Determination of Death*, 57. The report also clarifies (44–45) that "Patients diagnosed with total brain failure may retain certain limited brain functions (such as the secretion of ADH to regulate urine output), and they certainly retain enough somatic integrity to challenge claims that the body immediately becomes 'a disorganized collection of organs' once the brainstem is disabled. In addition, advances in intensive care techniques, displayed in cases of prolonged somatic 'survival' after 'whole brain death,' challenge claims that the body cannot continue in its artificially supported state beyond a short window of time."

[40] Ibid., 60: "With that account, death remains a condition of the organism as a whole and does not, therefore, merely signal the irreversible loss of so-called higher mental functions. But reliance on the concept of 'integration' is abandoned and with it the false assumption that the brain is the 'integrator' of vital functions. Determining whether an organism remains a *whole* depends on recognizing the persistence or 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."

needs.[41] The intention of most contributors was to say that the cases of brain-dead persons described by Shewmon fit this new definition [of when death occurs]. Thus they could be considered dead and their organs could be removed for the purpose of transplantation.

One could make a counterargument, however, by saying that these persons still interact with the external world by dint of their ability to maintain the functions of blood circulation and digestion, and also that of growth. Although they surely have lost the exercise of self-consciousness and interaction with others at the moral and intellectual level, they have nonetheless not lost their faculties that are essential in staying alive, which necessarily involves interacting with their environment.

One can likewise ask whether the intention that prevailed in shifting the criterion for death is not to be sought primarily in the pressure that is being exerted for the purpose of facilitating the removal of organs, because of a strong demand. Such an option would be counterintuitive because it seems to confirm the development of an ethic that is subject to the interests of those who are well. Our reflection on human death, but also on the criterion that allows us to determine the moment at which death occurs, ought to be entirely independent of the question of removing organs.

The main question raised by the cases to which Shewmon refers is whether the presence of certain "subsystems of integration" really signifies the presence of integrated and interdependent organic life that is capable of coordinating vital functions. To answer it, we would have to define much more precisely the meanings of "organism," "integrated vital function," and "holistic"— terms that are the object of a conceptual reflection resulting from a philosophy of biology supported by a scientific approach. We would also have to clarify what we mean by respiration and nutrition and whether these functions are exercised under the control of the organism (understood as an integrative unity) or independently of any such control. Moreover, another question left hanging in the air is whether we can speak about a living organism when it is kept alive artificially thanks to the technology of an artificial ventilator. This refers back to the distinction between "artificial life" and "natural life." Pieces of artificial equip-

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[41] Ibid., 61: "1. Openness to the world, that is, receptivity to stimuli and signals from the surrounding environment. 2. The ability to act upon the world to obtain selectively what it needs. 3. The basic felt need that drives the organism to act as it must, to obtain what it needs and what its openness reveals to be available."

ment that allow the organism to continue to live, such as a cardiac stimulator, are not, strictly speaking, essential parts of the organism. Although they help regulate vital functions to some extent, they do not initiate their activity.

This main question raised by the cases presented by the American physician is at the heart of the renewed interest that created the current debate. In the final analysis, this debate poses the question of whether artificial ventilation can be considered as a regulator of vital functions such that the organism is what actually controls them or, on the contrary, is the mechanical regulator that activates those same vital functions? In the latter case, the vital functions would be understood as a reaction, rather than as an action in which the principle of their activity is intrinsic to them. Indeed, we can think about the presence of a living organism as long as it possesses the potential to activate such vital functions by itself. If this is not the case, it would be better to speak about an "integrated machine,"[42] which although it can function as though we were dealing with a living organism, could be considered as living only by analogy and metaphorically.

It is ultimately a matter of determining whether the cases presented by Shewmon correspond to what can be described as organisms that instigate their integrative vital functions and interaction with the external world by themselves or, on the contrary, whether these functions and this interaction can be activated only by means of some mechanical assistance, in other words a cause outside the organism.[43] Finally, one may wonder whether we should not define human death independently of technological advances such as the ventilator or the cardiac stimulator, but also artificial nutrition and hydration.

Given that the question has not been broached definitively and that the study of the cases presented by Shewmon leaves room for a doubt that can be described as reasonable, we have a right to wonder

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[42] This is the term employed by Georges Cottier ("machine intégrée") in his "Questions for Neurologists and Others about Brain Death as the Criterion for Death," in *The Signs of Death: The Proceedings of the Working Group 11-12 September 2001*, ed. Marcelo Sanchez Sorondo, Scripta Varia 110 (Vatican City: Pontifical Academy of Sciences, 2007), XXXVII.

[43] See Quante, *Personales Leben und menschlicher Tod*, 156. See also Jason T. Eberl, "Ontological Status of Whole-Brain-Dead Individuals," in *The Ethics of Organ Transplantation*, ed. Steven J. Jensen (Washington, DC: Catholic University of America Press, 2011), 43–71, at 58. Eberl defends the view that the persons described by Shewmon are dead because they lack the active capacity to exercise the vital functions of circulation and respiration.

whether it is not necessary to cite the principle of precaution, which is summed up in the adage "when in doubt, leave it out." That is to say, in cases of doubt, the rule governing our action, as Jonas suggested together with the chairman of the committee that prepared the December 2008 report by the Presidential Council (ethicist Edmund Pellegrino), ought to be to lean prudently toward the side of life or, to be more precise, toward the likelihood of the presence of a human life.[44]

Some are against introducing this principle of precaution, citing Aristotle's argument that one cannot have absolute certainty in ethical matters.[45] Such a stance, however, leads to a shift in the debate. Indeed, the object of this discussion is not situated primarily on an ethical level, but rather on an anthropological and medical level, which then certainly has ethical consequences. Furthermore it is not necessary to require absolute certainty, because it is enough for there to be a reasonable probability that the human person is not dead at the time when he is considered brain dead. Hence we could declare that we are in the presence of a living organism.

Practical Consequences Concerning the Procurement of Organs

The implementation of the principle of precaution would imply that it would be problematic in present circumstances to continue the

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[44] See Hans Jonas, "Against the Stream: Comments on the Definition and Redefinition of Death," in *Philosophical Essays: From Ancient Creed to Technological Man* (New York: Atropos Press, 2010), 134–42, at 140: "We do not know with certainty the borderline between life and death, and a definition cannot substitute for knowledge. Moreover, we have sufficient grounds for suspecting that the artificially supported condition of the comatose patient may still be one of life, however reduced—i.e., for doubting that, even with the brain function gone, he is completely dead. In this state of marginal ignorance and doubt the only course to take is to lean over backward toward the side of possible life." This passage corresponds to "Gehirntod und menschliche Organbank: Zur pragmatischen Umdefinierung des Todes," in *Technik, Medizin und Ethik: zur Praxis des Prinzips Verantwortung* (Frankfurt am Main: Suhrkamp, 1987), 219–41, at 233. We find a similar position expressed by the chairman of the President's Council on Bioethics, Edmund D. Pellegrino, in his "Personal Statement," which is appended to *Controversies in the Determination of Death*, 107–21, esp. 117 and 119.

[45] See John Haas, "Absolute versus Prudential Certitude in Criteria for Determining Death," *Ethics and Medics* 33.7 (July 2008): 2, and Aristotle, *Nicomachean Ethics* 1.3.1094b24, trans. David Ross (Oxford, UK: Oxford University Press, 1986), 3.

practice of procuring organs from human beings who are brain-dead but nevertheless continue to live with the help of a ventilator. To do this would be to violate the fundamental Dead Donor Rule. A drastic reduction in the number of organs procured would follow, whereas the present supply is already generally insufficient to respond to the demand.[46]

In order to overcome this difficult situation, some propose abandoning anthropological and medical considerations and situating the debate solely on the ethical level, a shift that goes hand in hand with the abolition of the principle enshrined in the Dead Donor Rule. Truog summarizes their reasoning as follows: "The process of organ procurement would have to be legitimated as a form of justified killing, rather than just as the dissection of a corpse."[47] After presenting and critiquing the arguments in favor of abolishing the Dead Donor Rule, I will show that the patients mentioned by Shewmon are in a situation that could be said to result from therapeutic obstinacy. While citing the principle of precaution, as well as the Dead Donor Rule, I will argue that we should consider a person deceased when we observe brain death accompanied by cardiac death.

Abolition of the Dead Donor Rule

Since the debate is being shifted in this way, the central issue is no longer to say what human death is while citing an anthropological definition and thus determining, on the basis of a medical criterion, at what moment a human being is dead. The issue is rather, as the American philosopher James Rachels puts it, to determine "at what point is it morally all right to declare [the person] dead?" or "at what point is it morally all right to remove his organs?"[48] With regard to the physician's

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[46] See, for example, James L. Bernat, "The Whole-Brain Concept of Death Remains Optimum Public Policy," *Journal of Law, Medicine & Ethics* 34 (2006): 35–43.

[47] Robert D. Truog, "Is it Time to Abandon Brain Death?" *Hastings Center Report* 27.1 (January–February 1997): 29–37, at 34. See also Seema K. Shah, Robert D. Truog , and Franklin G. Miller, "Death and legal fictions," *Journal of Medical Ethics* 37.12 (2011): 719–22; Franklin G. Miller and Robert D. Truog, "Rethinking the Ethics of Vital Organ Donation," *Hastings Center Report* 28.6 (2008): 38–46; and Norman Fost, "The Unimportance of Death," in *The Definition of Death: Contemporary Controversies*, ed. Stuart J. Youngner, Robert M. Arnold, and Renie Schapiro (Baltimore, MD: Johns Hopkins University Press, 1999), 161–78.

[48] James Rachels, *The End of Life*, (Oxford, UK: Oxford University Press, 1986), 42.

hesitation in deciding the "right" moment to unplug the ventilator, another American philosopher, Jonathan Glover, proposes shifting the question to the ethical level alone while disregarding the impossibility of determining with absolute certainty the time of death. Then it would instead be a matter of asking "whether or not we attach any value to the preservation of someone irreversibly comatose"[49] (or, we might add, to the preservation of the persons described by Shewmon).

This is the question that Stoecker posed to the German Ethical Council. In doing so, he merely endorsed the position of a number of Anglo-Saxon thinkers, such as Robert Veatch[50] or Peter Singer, to whom the definition of death is not a scientific but an ethical matter. The Australian philosopher explains that the definition of brain death is "a convenient fiction that turns an evidently living being into one that legally is not alive. Instead of accepting such fictions, we should recognize that the fact that a being is human, and alive, does not in itself tell us whether it is wrong to take that being's life."[51] Stoecker's argument, the intention of which is to shift the debate to the ethical level alone, is based nevertheless on a certain anthropological approach. According to him, the brain-dead human being is considered dead from personal perspective—that is, in terms of the definition of the human person—but living from the biological perspective. The individual is situated in the gray area between death and life, a "twilight zone" that is "neither here nor there":[52] "What one quickly and effortlessly observes is the fact that these patients are still like the living in one respect—in their outward appearance and in many bodily functions—and in another respect are already like the dead—in their definitive helplessness and the hopelessness of their situation. . . . These [brain-dead] patients are in personal terms like the dead, and in other respects like the living."[53]

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[49] Jonathan Glover, *Causing Death and Saving Lives* (New York: Penguin, 1982), 45. He continues: "Do we value 'life' even if unconscious, or do we value life only as a vehicle for consciousness?"

[50] See Robert M. Veatch, *Death, Dying and the Biological Revolution: Our Last Quest for Responsibility* (New Haven, CT: Yale University Press, 1976–1977; rev. ed. 1989).

[51] Singer, *Rethinking Life and Death*, 105. See also Birnbacher, "Das Hirntodkriterium in der Krise," 36.

[52] Ralf Stoecker, "Das Transplantations-Trilemma als philosophische Aufgabe," *Deutsche Zeitschrift für Philosophie* 60.3 (2012): 426–27, at 427: "Hirntote Patienten befinden sich in einem Vagheits-Bereich; halb sind sie noch am Leben und halb schon tot."

[53] Stoecker, "Der Hirntod aus ethischer Sicht": "Was man schnell und mühelos

The argument that Stoecker proposes in favor of procuring organs from a brain-dead human being consists of stating first—while paradoxically using an anthropological criterion—that, even though he is alive on the biological level, he is dead on the personal level. In other words, he is no longer alive at the level of what the German philosopher describes as being "the normative meaning of life."[54] From this it follows, therefore, that one could not harm him in the least by removing his organs. Moreover, the recipient of the organs would benefit from them more than he does: "It is no longer possible to cause them pain or joy. . . . And because it is no longer possible to do them harm, or to deprive them of any future, and because on the other hand the organ recipients profit considerably from the transplantation, one may remove organs from them, and do so, even though it leads to the termination of their condition between life and death and makes dead people out of the brain-dead."[55]

This argument is based on an unproved *a priori* assumption: If a

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feststellt ist, dass diese Patienten in der einen Hinsicht noch wie Lebende sind–in ihrem äußeren Anschein und vielen körperlichen Funktionen–und in der anderen Hinsicht schon wie Tote–in ihrer definitiven Ohnmacht und der Aussichtslosigkeit ihrer Situation. […] Diese Patienten [hirntote] sind in personaler Hinsicht wie Tote sind, in den anderen Hinsichten wie Lebende." See also Stoecker, "Der Tod als Voraussetzung der Organspende?" 106, 111, and 112. We find a similar argument penned by Ruth Denkhaus and Peter Dabrock in "Grauzone zwischen Leben und Tod: Ein Plädoyer für mehr Ehrlichkeit in der Debatte um das Hirntod-Kriterium," *Zeitschrift für medizinische Ethik* 58.2 (2012): 135–48, at 142. Shah, Truog, and Miller defend a similar point of view: "People who are 'brain dead' maintain a host of life functions that a corpse cannot. This condition of profound brain damage is like death because both states are marked by the permanent loss of consciousness and the ability to interact with others. Given that most people would see no point in maintaining life support for patients in this condition, they are 'as good as dead,' making it reasonable to treat them as if they were dead so that their organs can be used to save the lives of others. It therefore makes sense to treat a diagnosis of 'whole brain death' the same as death for the purpose of determining when organ donation is legally permissible" ("Death and legal fictions," 720–21).

54 Stoecker, "Der Tod als Voraussetzung der Organspende?" 111: "die normative Bedeutung des Lebens."

55 Stoecker, "Der Hirntod aus ethischer Sicht": "Man kann ihnen nicht mehr wehtun oder ihnen Freude bereiten. . . . Und weil man ihnen kein Leid mehr antun, sie keiner Zukunft berauben kann und weil auf der anderen Seite die Organempfänger erheblich von der Transplantation profitieren, darf man ihnen Organe entnehmen, und das, obwohl es dazu führt, dass sie ihren Zustand zwischen Leben und Tod beenden und aus den hirntoten tote Menschen werden."

particular human being has no conscious interest that is deliberately expressed (and therefore empirically observable) in staying alive, no harm would be done to him by killing him, since none of his interests would be violated. In other words, in the name of an ethic of interests, we can move beyond the Dead Donor Rule.

We find a similar proposal penned by Birnbacher, who discusses the case of the brain-dead person while continuing to consider him alive: "In contrast to the case of a typical victim of killing, organ donation here entails no loss of subjectively experienced time of life for the organ donor. Since all brain functions are irreversibly lost with brain death, all functions of consciousness are lost too. A temporal difference between the occurrence of brain death and the occurrence of biological death does not mean that this difference can be experienced somehow. This objective difference has no subjective counterpart. Whether or not one equates brain death with death—consciousness is irreversibly gone with brain death."[56]

Birnbacher's argument is based on the a priori assumption that, from the ethical perspective, only the exercise of a conscious mental life has any value. A human existence irreversibly deprived of it would have no value: "Not the preservation of the life of the organism, but rather the preservation of the life of consciousness is undoubtedly a good in practically any ethical system."[57] Although acknowledging that the human beings described by Shewmon are alive, the German philosopher declares himself to be in favor of keeping the brain-

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[56] Birnbacher, "Das Hirntodkriterium in der Krise," 37: "Anders als bei einem paradigmatischen Tötungsopfer bedeutet die Organspende für den Organspender keinen Verlust an subjektiv erlebbarer Lebenszeit. Da mit dem Hirntod alle Hirnfunktionen irreversibel erloschen sind, sind auch alle Bewusstseinsfunktionen irreversibel erloschen. Eine zeitliche Differenz zwischen dem Eintritt des Hirntods und dem Eintritt des biologischen Tods bedeutet nicht, dass diese Differenz irgendwie erlebt werden kann. Diese objektive Differenz hat kein subjektives Gegenstück. Ob man den Hirntod mit dem Tod gleichsetzt oder nicht–das Bewusstsein ist mit dem Hirntod irreversibel verlorengegangen." Richard Zaner uses similar arguments in his plea for the procurement of organs from anencephalic infants, while clearly insisting on the presence of interests that must be exercised: "Finally, where there are *no* neurological supports for personal, conscious life, there is no reason to suppose that an individual has interests of its own, in the strict sense in which the person does"; see his "Anencephalics as Organ Donors," *The Journal of Medicine and Philosophy* 14.1 (1989): 61–78, at 67–68.

[57] Birnbacher, "Der Hirntod—eine pragmatische Verteidigung," 474: "Nicht die Erhaltung des organismischen Lebens, sondern die Erhaltung des Bewusstseinslebens ist ein von so gut wie keinem ethischen System bezweifeltes Gut."

death criterion for an ethical reason, because it attributes maximum certitude to the irreversible character of the loss of the exercise of a conscious mental life. What we do to a living human organism that is considered brain dead has no importance, given that we cannot deprive it of a conscious life. "The brain-death criterion," Birnbacher explains, "is not an adequate criterion *for death*, but rather a criterion for *mental death*, which is not simply speaking identical to death yet is primarily relevant from ethical perspectives."[58]

In order to be able to say that a subject has been wronged, the two German philosophers and those who propose abolishing the Dead Donor Rule highlight a central requirement, namely the presence of conscious mental life, accompanied by the exercise of interests; this implies, logically, that it would be permissible to procure organs not only from a brain-dead human being but also from any human being in a similar situation. Think, for example, of those who are in a so-called "vegetative"[59] state or of an anencephalic infant—a recommendation made, incidentally, by Robert D. Truog,[60] Don Marquis,[61] Norman Fost,[62] and Jeff McMahan. The last-mentioned explains that "because an anencephalic infant has neither the capacity nor the potential for consciousness, it is not a bearer of interests. Nothing can matter, or be good or bad, for its sake. Nor can it have rights or be an appropriate object of respect. If, therefore, the view for which I have argued is correct, it is difficult to see what objection

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58 Ibid., 475: "Das Hirntodkriterium ist kein adäquates Kriterium *für den Tod*, sondern ein Kriterium für den unter ethischen Gesischtspunkten primär relevanten, aber mit dem Tod *simpliciter* nicht zusammenfallenden *mentalen Tod*." See also Birnbacher, "Der Hirntod–der Tod? " 423. He explains however that this certitude about the loss of conscious life is not attained in the case of a human being in a so-called vegetative state or in the case of an anencephalic infant. It follows, in his opinion, that one could not, from an ethical perspective, procure their organs.

59 See Ronald E. Cranford and David R. Smith, "Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood," *American Journal of Law and Medicine*, 13.2–3 (1987), 233–48, at 246–47. See also Marquis, "Abortion and the Beginning and End of Human Life," 23, and Fost, "The Unimportance of Death," 172.

60 See Truog, "Is it Time to Abandon Brain Death?" 34: "Individuals who could not be harmed by the procedure would include those who are permanently and irreversibly unconscious (patients in a persistent vegetative state or newborns with anencephaly) and those who are imminently and irreversibly dying."

61 See Marquis, "Abortion and the Beginning and End of Human Life," 23–24.

62 See Fost, "The Unimportance of Death," 172.

there could be to taking the organs from a living anencephalic infant for transplantation—apart, of course, from objections based on the interests and rights of the parents."[63]

If we wanted to argue consistently from these premises, which for these two German philosophers, among others, are based on the lack of an interest and of a future that would make sense for the subjectivity of the individual, one could likewise mention the possibility of removing organs, as Fost[64] recommends, from persons who are in the terminal phase of their life or suffering from a fatal illness, or even, as Veatch[65] speculates, from persons who wish to commit suicide or from others who have been sentenced to the death penalty. The procurement of organs in these cases, however, would be possible only if the donor freely gave his so-called "informed" consent. As for Miller and Truog, they propose replacing the requirement of the Dead Donor Rule with the more central requirement of consent.[66] Finally, one might ask whether it would be possible also to procure organs from human beings who cannot or can no longer consent to it, delegating the consent then to a relative or friend who is capable of making the decision. This would be the case with very young children, newborns, or persons with a severe and irreversible mental handicap or in the late stages of Alzheimer's disease.[67]

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63 McMahan, *The Ethics of Killing*, 451. See also Robert C. Cefalo and H. Tristram Engelhardt, "The Use of Fetal and Anencephalic Tissue for Transplantation," *The Journal of Medicine and Philosophy* 14.1 (1989), 25–43.

64 See Fost, "The Unimportance of Death," 174.

65 See Robert M. Veatch, "Abandon the Dead Donor Rule or Change the Definition of Death? " *Kennedy Institute of Ethics Journal* 14.3 (2004), 261–76, at 269.

66 Miller and Truog, "Rethinking the Ethics of Vital Organ Donation," 44. They also defend the ethical possibility, in some circumstances, of procuring organs from persons who are in good health, provided that they give their consent. See also Franklin G. Miller, Robert D. Truog, and Dan W. Brock, "The Dead Donor Rule: Can It Withstand Critical Scrutiny?" *Journal of Medicine and Philosophy* 35.3 (2010), 299–312, at 308. Their argument is based on the assumption that what the subjective will desires can be authorized, provided that it does not involve a third party.

67 Robert M. Veatch mentions cases that follow from the first principle of consent—it would make permissible the procurement of organs not only from brain-dead or irreversibly unconscious persons by killing them, but also from infants and those with profound mental handicaps—but he explains that the implementation of this principle would be very complicated at the legal and societal level; see "Transplanting Hearts after Death Measured by Cardiac Criteria: The Challenge to the Dead Donor Rule," *Journal of Medicine and Philosophy* 35.3 (2010): 313–29, at 327.

Critique of the Call for the Abolition of the Dead Donor Rule

Stoecker's position, like that of his Anglo-Saxon predecessors, relies chiefly on an a priori assumption that can be challenged seriously: in order for harm to be done to someone, it is also necessary for him to be able to experience it and capable of expressing an interest.[68] Now, in order to be sure of the presence of an interest and of possible harm, they presuppose that the following statement is true: What one cannot observe empirically does not exist. Such a postulate implies, in fact, a reductively behaviorist perspective. Indeed, if a human being does not consciously express a particular interest that is empirically observable, that does not necessarily imply that he does not have such an interest. Two arguments illustrate this. On the one hand, although we do not presently have the technological means allowing us to register the presence of a mental life and, therefore, of subjective interests in persons who are in a particular situation such as one in a so-called "vegetative" state, this does not imply de facto that such a mental life quite simply does not exist. Rapid technological advances may allow us to detect, in the more or less near future, the presence of this mental life suited to expressing interests. On this topic we might mention, by way of example, this recent fact: it was possible to enter into communication with a person—thirty-nine-year-old Scott Rowley—who has been in a so-called profound "vegetative" state since an automobile accident that occurred twelve years ago, and for his part, he expressed interests.[69]

In the second, more fundamentally argument, one can assert the presence of interests that are constituent of a human being independently of their concrete exercise. Consider the hypothetical case of a person in a so-called vegetative state who was filmed while relieving himself. The film was later shown. The average person's sense of common decency would be offended by that because such an act would profoundly harm the interest of that human being if he was considered as an end in himself. Such an interest is constitutive

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[68] It is very interesting to note that this a priori assumption is also at the basis of the thesis recently developed by Alberto Giubilini and Francesca Minerva in favor of euthanasia for newborns, or what they call "post-natal abortion." Their argument also implies the possibility of removing and transplanting the vital organs of these newborns, provided their parents give their consent; see "After-birth abortion: why should the baby live?" *Journal of Medical Ethics* online, February 23, 2012 (doi:10.1136/medethics-2011-100411).

[69] Determining whether or not Scott Rowley really is in a so-called vegetative state is of secondary importance here.

of a human being, even if he were not conscious of it; it is present even in the case where the human being is in a state that makes him unable, or else never has been able, to exercise such an interest consciously. The harm that is done him is not based on a conflict with his subjective interest, but rather on a constitutive interest of his as a human being, based on his ontological dignity. Such an interest exists independently of any act of consciousness by the subject or of its empirically observable concrete expression. The question of whether or not the human being subjectively feels the harm that is done him in procuring his organs is not the factor that determines the ethical value of that act. The central question, rather, is whether harm is done him if someone procures his organs. This leads ultimately to the question of whether the death of a human being is an evil in itself.[70]

Moreover, as I already said, the abolition of the Dead Donor Rule based on the theory of subjective interests and the legitimacy of organ transplantation applies not only to the human beings described by Shewmon or to those who are brain-dead, but rather it de facto implies the lawfulness of killing any human being who is in a similar situation, anyone who does not exercise personal interests and self-consciousness. Proponents of abolishing the Dead Donor Rule agree with the defenders of neocortical death here. The effect of this would be to introduce subtly a sort of justification of slavery within the human species based on the principle of utility: in the final analysis some human beings—such as newborn infants, severely mentally handicapped persons, or senile ones—would be reduced to supplying a bank of living organs destined for other human beings.

Stoecker's proposal, therefore, is to introduce a third category: a fluctuating or intermediate state between death and life. This obliges him to make a distinction between two categories: biological human life strictly speaking and so-called "personal" human life. Describing different types of human existence—biological, biographical, interactive, and phenomenal—he asserts that a human life has a normative value insofar as all these elements are present and actualized. If one of them were to be missing, he explains (without however providing explicit arguments), the normative value of the life would vanish. From then on, one could remove the individual's organs: "Only if he has already lost his life in this sense, we might say, can his organs

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[70] See Bernard N. Schumacher, *Death and Mortality in Contemporary Philosophy* (Cambridge, UK: Cambridge University Press, 2011), 182–212.

be removed. . . . The fundamental ethical assumption about life and death therefore applies only in instances where all the signs of life are present."[71]

The introduction of this "neither-here-nor-there" state presupposes a dualist anthropology, one that is explicitly defended, moreover, by proponents of brain stem death and neocortical death. Contrary to the latter, who try to justify this dualist anthropology by citing mainly John Locke as the source of the positions from which they deduce these ethical consequences, Stoecker relies on a theory of moral values. He assigns normative value only to the second type of human existence, so-called "personal" life, which includes the presence of organic life, unlike the first type of human existence, which is situated solely at the level of the organism and is devoid of the constituent elements of so-called "personal" life.

The distinction advanced by Stoecker, which we find also in Birnbacher's writings, actually results from a very debatable ethical choice and by no means from an anthropological reflection accompanied by a biological and medical approach. This approach does not warrant the presence of an intermediate state, since the death of a human being is defined as the radical denial of the various faculties or capacities that constitute organic life. As the German philosopher Andrea Esser neatly explains, "the biological understanding of the terms 'life' and 'death' allows for no *intermediate state*, no *fluctuating state* and no *gray area*."[72]

The proposal of Stoecker and Birnbacher to abandon the field of medical science and that of philosophical anthropology so as to situate reflection about death exclusively on an ethical plane while specifically no longer requiring compliance with the Dead Donor Rule in order to procure vital organs raises another fundamental problem: one might say that this is an epistemological error. Indeed, if a human being were to consider one day, from the subjective viewpoint, that he no longer had a future in which to accomplish his goals, his inter-

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[71] Stoecker, "Der Tod als Voraussetzung der Organspende?" 111–12: "Nur wenn er das Leben in diesem Sinn schon verloren hat, will man sagen, darf man ihm die Organe entnehmen. . . . Die ethische Grundannahme über Leben und Tod gilt deshalb nur dort, wo alle Merkmale des Lebens erfüllt sind."

[72] Andrea M. Esser, "Menschen sterben als Personen," in Andrea Esser, Daniel Kersting, and Christoph G. W. Schäfer, *Welchen Tod stirbt der Mensch?* (Frankfurt am Main: Campus, 2012), 221–42, at 234: "Das biologische Verständnis der Begriffe 'Leben' und 'Tod'' lässt kein *Zwischenzustand* zu, keinen *Schwebezustand* und keine *Grauzone*."

ests, the continuation of his existence would be deprived of meaning. Such a situation—just like the ones described by Shewmon—does not imply however in any case that such a human being is de facto dead. Indeed, the definition of human death, which results from a philosophical anthropological reflection—just like the criterion allowing the determination of the death of a human being, which for its part results from a scientific medical reflection—implies no ethical value judgment. In fact, neither the definition of death nor its criterion can determine what sort of existence—with or without self-consciousness—is or is not worth the trouble of living. These are two radically different sorts of discourse. The quality of life, to which Stoecker and Birnbacher implicitly refer, which is based on a utilitarian, consequentialist ethics, cannot be a pertinent criterion for analysis in an investigation into the nature of death any more than it allows us to determine whether life is still present in a particular individual, or in other words, whether he is dead. Similarly, we have here also two distinct sorts of discourse when we speak about human life in general and about the quality of a human life and of its value.

In short, the question of whether a human being is dead can be debated and one can answer it without asking whether his life seems desirable to him from a subjective viewpoint. Such an anthropological thanatological reflection is in no way related—Stoecker's dogmatic statements notwithstanding—to "desperate attempts" to find out whether a person in a particular situation is deceased. Even though it is a difficult endeavor, it is better to continue, in the name of the principle of precaution, to conduct research at the scientific level to try to identify with as much certainty as possible the criterion that allows us to declare that death has occurred. Furthermore, this research is based on a philosophical anthropological foundation, which in any case is not a "useless" and "superfluous"[73] speculative endeavor. Quite the contrary, ethical reflection is, in the final analysis, conducted within the framework of a philosophical anthropology with human nature as its object, and more particularly human death.

Therapeutic Obstinacy

Some have claimed—wrongly, in my view—that the only possible way to continue procuring organs from brain-dead persons is to shift the

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[73] Stoecker, "Der Tod als Voraussetzung der Organspende?" 115: "Die verzweifelten Versuche," "überflüssig"; and 113: "von der fruchtlosen Hirntod-Debatte" [that is based on an anthropological approach].

debate to the ethical level. This shift not only causes several problems in argumentation but also has consequences that defy common sense. Is it therefore necessary to stop removing organs from brain-dead persons, given that they are alive? I do not think that it is right to raise the specter of an organ shortage. Indeed, we could consider that the life of these living persons, who are dead at the cerebral level, would have ended if no one had decided to intervene. They would be, from a certain perspective, "dying" persons who were being kept alive with the help of artificial assistance, regardless of whether these life-sustaining procedures are conducted inside or outside the person's organism. One may ask whether we are not looking at a situation that could be described as therapeutic obstinacy or disproportionate treatment. Indeed, the means employed would be both extraordinary and disproportionate. It is reasonable to postulate that a patient who is alive but brain-dead could have decided, while still capable of it, based on a so-called "informed" prudential judgment, that if he were ever in such a situation, the methods involved in his care and treatment would be disproportionate in relation to the therapeutic benefit that they would bring him personally. He could decide to be placed on a "do not resuscitate" (DNR) in the event that he is diagnosed with total brain failure. If he were to consider rationally that this care brought him no significant benefit, he could legitimately decide to discontinue the treatment, and even (in the case under discussion) to unplug the ventilator, so as to die a natural death. The patient, indeed, has a fundamental right to refuse any medical treatment that is perceived as disproportionate, the right not to be the prisoner or slave of medical techniques that only postpone death. This right to die, to use an expression of Jonas,[74] which is expressed by the voluntary cessation of treatments, thus allowing the human being to die, is to be distinguished from the act of putting oneself to death (euthanasia or assisted suicide). This right comes into play when the person realizes that the care being lavished on him is not aimed at his cure and brings about no improvement, not even the slightest, of his state of health. Remission is no longer possible; his situation is, from the human perspective, desperate, devoid of hope. His state can fairly be likened to the state of a prisoner who is condemned to death with no chance of pardon.[75]

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[74] See Hans Jonas, "The Right to Die," *Hastings Center Report* 8.4 (1978): 31–36.

[75] See Bernard N. Schumacher, "L'espérance au cœur de la vie humaine. Enjeux autour du malade d'Alzheimer," in *Alzheimer: une personne quoi qu'il arrive*, ed. Thierry Collaud, Véronique Gay-Crosier, and Magdalena Burlacu (Fribourg: Academic Press, 2013), 45–66.

The fundamental right to refuse to continue treatment requires, however, consent on the part of the patient. This consent is different from what Trugo and Miller, or Birnbacher, think it is in the context under discussion. According to them, it would make no difference whether death occurred as the result of shutting off the ventilator or procuring organs from human organisms that are considered alive because the ultimate criterion lies exclusively in the consent of the patient or of his proxy, regardless of the requirement of the Dead Donor Rule: "With such a consent, there is no harm or wrong done in retrieving vital organs before death."[76] The harm or the wrong done to someone depends ultimately no longer on the act committed—insofar as it concerns only this specific person—but solely on whether or not his consent is respected.[77]

This right to die within the context of therapeutic obstinacy can be chosen by the patient at the time, or else anticipating a situation, for example the one described by Shewmon. If however it should happen that the patient not only is no longer capable of making such a judgment but also never made it in advance, everything would depend on the prudential judgment (combined with common sense) of his family, of his friends, or of his personal caregiver. However, if the patient and his family, his friends, and his personal caregiver were to consider the means being employed proportional and ordinary, the care would have to be continued.

This position is worthwhile, provided that we specify what we mean by ordinary and extraordinary measures in difficult cases. There are situations in which the line between them is not clear. There is no pat solution. Indeed, as Aristotle nicely puts it, particular

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[76] Robert D. Truog and Franklin G. Miller, "The Dead Donor Rule and Organ Transplantation," *New England Journal of Medicine* 359.7 (2008): 674–75: at 675. See also Miller and Truog, "Rethinking the Ethics of Vital Organ Donation," 44: "The key protection is consent, along with the requirement for a valid decision to withdraw life support: organs should not be extracted without the valid consent of either the donor or an appropriate surrogate decision-maker." See also Birnbacher, "Das Hirntodkriterium in der Krise."

[77] We find a similar position in the thesis defended by the French philosopher Ruwen Ogien, who speaks about victimless moral crimes and recommends avoiding the use of the word "immoral" "to evaluate anything in our lifestyles, our thoughts, our actions, that concerns only ourselves and what we do between consenting persons"; see *L'Éthique aujourd'hui: Maximalistes et minimalistes* (Paris: Gallimard, 2007), 23: "immoral" . . . "pour évaluer tout ce qui, dans nos façons de vivre, nos pensées, nos actions, ne concerne que nous-mêmes, ce que nous faisons entre personnes consentantes ."

cases "do not fall under any art [technique] or precept [traditional prescription]. . . . The agents themselves must in each case consider what is appropriate to the occasion, as happens also in the art of medicine or of navigation."[78] The decision to be made depends on prudential practical wisdom, acquired by experience, that connects general rules to singular situations. In every case, one ought to respect the so-called informed consent of the patient who in conscience refuses to prolong particular treatments that he deems extraordinary, that do not contribute to a therapeutic result that is significantly beneficial to him. This choice, however, must not be influenced in any way by any pressure whatsoever with a view to procuring organs, not even in the name of the principle of solidarity and compassion. This comes down to separating the two aspects clearly: the decision to stop the treatment that maintains the vital functions must be made before any reflection as to the possibility of donating organs. Moreover, it is necessary that the situation in which the living person described by Shewmon finds himself be irreversible—in other words, that is not possible for his brain to perform again a minimum of its functions independently of artificial assistance.

The possibility of considering the lawfulness of unplugging a ventilator that is sustaining a living person who is brain-dead by citing therapeutic obstinacy does not resolve, however, the question about organ transplantation. One proposal would be to procure a patient's organs—in the specific case of persons who are alive but brain-dead—after the determination of cardiac death—that is, "cardiac arrest"—since the circulatory and respiratory functions have ceased. Two categories of persons are commonly distinguished: first, those who have suffered a sudden heart attack, a situation described as "uncontrolled cardiac arrest," and second, those who have decided to stop their treatment and whose death by cardiac arrest is then expected after a more or less brief interval, a situation described as "controlled cardiac arrest." The procurement of organs from a person whose heart has stopped and who has previously given his consent is carried out after the determination of the irreversibility of the cardiac arrest. The waiting period before procurement currently varies (commonly between two minutes, according to the Pittsburg protocol, and ten minutes, according to the Maastricht protocol).

The short delay allowed by the protocols raises a series of ethical

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[78] Aristotle, *Nicomachean Ethics* 2.2.1104a7–10 (p. 30).

questions, however.[79] First of all, the two-minute interval does not allow a certification with absolute certitude of irreversibility; in other words, it does not guard against the Lazarus effect, the "resurrection" of the person whose heart spontaneously begins to beat again.[80] Proponents of this interval say that the medical personnel respect the patient's decision that no one should intervene for the purpose of reversing the state in which he finds himself—in other words, of reviving him. Nevertheless, in the case where the patient could have revived by himself and yet his organs had been procured, we would have to declare that he had been put to death in order to procure his vital organs for the benefit of another person. To date, Joanne Lynn and Ronald Cranford[81] point out, we have no empirical studies proving with absolute certainty how long after the cessation of circulation a spontaneous recovery of that circulation could occur. However, one could follow Shewmon in proposing, so as to have a maximum assurance not going against the Dead Donor Rule, an interval anywhere from twenty to thirty minutes before any authorization to procure organs, to which one would previously have administered a medication so as to preserve them better. This time lapse does not seem to pose a problem of deterioration in the quality of the organs, whether we are speaking about the liver, kidneys, lungs, or even the heart.[82]

The claim that such an intervention would amount to killing a person, given that these organs are still alive, can be refuted on account of the fact that the personal organism is already deceased at the moment of procurement. Indeed, as the American philosopher Christopher Kaczor[83] explains, we are no longer dealing with an

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79 See Truog and Miller, "The Dead Donor Rule and Organ Transplantation," and James M. Dubois, "Non-Heart-Beating Organ Donation: A Defense of the Required Determination of Death," *Journal of Law, Medicine & Ethics* 27.2 (1999): 126–36.

80 Although a small study suggests that two minutes of absent circulation is sufficient to certify death, see Michel A. DeVita et al., "Observations of Withdrawal of Life-sustaining Treatment from Patients who Became Non-heart-beating Organ Donors," *Critical Care Medicine* 28.6 (2000): 1709–12.

81 See Joanne Lynn and Ronald Cranford, "The Persisting Perplexities in the Determination of Death," in *The Definition of Death: Contemporary Controversies*, ed. Stuart Youngner, Robert M. Arnold, and Renie Schapiro (Baltimore, MD: Johns Hopkins University Press, 1999), 101–14 and 108–09.

82 See Christopher Kaczor, "Organ Donation following Cardia Death: Conflicts of Interest, Ante Mortem Interventions, and Determinations of Death," in *The Ethics of Organ Transplantation*, 95–113, at 112–13.

83 See ibid., 113.

organism that is an integrally functioning whole, but rather with the functioning of various organs that are not integrated into a unified whole. We find such a proposal, presented in very general terms, in the writings of Jonas: "The artificial ventilation is stopped first and then time is allowed in order to determine the definitive absence of all signs of life, and only then does the removal of organs begin. Since the delay is short, this would still result in usable material, but the conditions would no longer be optimal, and the yield would probably be smaller as a result."[84] This proposal, if implemented, would make it possible to reconcile respect for the patient's will and the requirement of the Dead Donor Rule.

Conclusion

The recent debate calling into question the criterion of brain death does not lead automatically to the prohibition of organ procurement, nor does it justify any organ procurement whatsoever, provided that the requirement of the Dead Donor Rule is abolished. The proposal of advocates of neocortical death, which consists of shifting the debate to the ethical level exclusively and basing decisions on a consequentialist utilitarian approach, citing the serious shortage of vital organs available, subtly introduces a hierarchy among human beings—in other words a frontal attack on the fundamental equality of all human beings. Such a shift would imply the exploitation of some human beings and would lead to regarding others, and more particularly those who are extremely frail and dependent, as "the freshest material for organ transplantation,"[85] while justifying this on the basis of the theory of the gift or even setting up a moral imperative in the name of a compassion that would oblige someone to give parts of his body to a third person who would be more capable of making good use of them—in other words, an ethics that viewed organs in terms of profitability.

For my part I would say that there is no pragmatic difference with regard to organ procurement if we consider Shewmon's research.

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[84] Hans Jonas, "Gehirntod und menschliche Organbank," 239: "[D]aß man zunächst die künstliche Atmung einstellt, dann die Zeit läßt, um die endgültige Abwesenheit aller Lebenszeichen festzustellen, und danach erst mit der Organentfernung beginnt. Das würde, da die Verzögerung kurz ist, immer noch brauchbares Material erbringen, aber die Bedingungen wären nicht mehr die optimalen, die Ausbeute daher wohl geringer."

[85] Hans Jonas, "Techniken des Todesaufschubs und das Recht zu sterben," in *Technik, Medizin und Ethik: zur Praxis des Prinzips Verantwortung* (Frankfurt am Main: Suhrkamp, 1987), 242–68, at 260: "frischsten Materials für Organverpflanzung."

Indeed, in the great majority of human organisms that are suffering from irreversible brain damage that leads to brain death, we observe significant damage to the cardiovascular system also, which is then incapable of functioning autonomously and without assistance. In more particular cases, those of the persons described by Shewmon, we could say that they are in a situation resulting from therapeutic obstinacy, and thus we could propose the cessation of treatment that would lead to their death, provided that the person in question (or at least his family, his friends, or his caregiver) had given consent in advance. Nevertheless, in this hypothetical situation, in order to be sure that one does not kill a person for the purpose of procuring his organs, we could envisage the requirement of a twofold diagnosis: determination of brain death accompanied by determination of cardiac arrest.

N. V