‘Brain Death,’ Organ Donation, and Presumed Consent*

Consent Cannot Be Presumed because ‘Brain Death’ Is Not True Death

Doyen Nguyen†

2019

*The Text is available under the Creative Commons License Attribution 4.0 International (CC BY 4.0) – Publication date: 24.03.2019.
†Doyen Nguyen, M.D., S.T.D. is both a moral theologian and a physician specialized in hematopathology. A graduate of Temple University Medical School and a scholar of the Leopold Schepp Foundation, she is a lay Dominican and a Professor of Theology at the Pontifical University of St. Thomas Aquinas (Angelicum) in Rome where she obtained her doctorate in moral theology, specializing in end-of-life ethics. Epost: btursiopsdnXYZcom (replace ‘XYZ’ by ‘@gmail.’) Institution: Pontifical University of St. Thomas Aquinas, 1 Largo Angelicum, Rome, Italy.
# Contents

1 Introduction 7

2 On Consent in Organ Donation 11

2.1 The Personalistic norm, the Ethical Foundation of Consent 14

2.2 The Lack of Transparent Disclosure to the Public about ‘Brain Death’ 17

2.3 On Presumed Consent: Why Consent for Organ Procurement Cannot Be Presumed 24

2.3.1 Pope Pius XII’s Teaching on Post-mortem Organ Donation 24

2.3.2 The Utilitarian and Presumptuous Character of Presumed Consent 27

2.3.3 The Deceptive Character of Presumed Consent in Organ Donation 32

3 Organ Transplantation, the Direct Cause of the Genesis of ‘Brain Death’ 35

3.1 Key External Events Leading up to the Formation of the Ad Hoc Harvard Committee 41

3.1.1 Mollaret and Goulon ‘le coma dépassé’ (irreversible coma) 41

3.1.2 The Ciba Foundation Symposium on Ethics in Medical Progress 43

3.1.3 Barnard’s ‘Sensational’ Heart Transplantation 46
3.2 The Genesis of the Harvard Report . . . . . 48
3.2.1 The Harvard Committee’s Alleged Justifications for Identifying Irreversible Coma (‘Brain Death’) with Death . . 49
3.2.2 The Harvard Committee’s True Justification for Identifying Irreversible Coma (‘Brain Death’) with Death . . 53
3.3 Does Changing the Definition of Death Change the Reality of the Phenomenon of Death? . . 59

4 Conclusion 63
Abstract

The marked decline in organ donation in Germany in recent years has once again brought the debate on the opt-out policy into the spotlight of German politics. Until now, Germany has remained one of the few European countries where the opt-in system for ‘postmortem’ organ donation is still in force. In mid-2018, however, the Health Minister, Jens Spahn, proposed a bill to change the current opt-in to an opt-out system in order to increase the supply of transplant organs. This bill is to be decided by the Bundestag in the coming months of this year (2019). The current debate in Germany on organ donation legislation effectively touches not just on the controversial concept of presumed consent (the basis for the opt-out policy) but also on the intractable ‘brain death’ controversy, because the bulk of alleged ‘postmortem’ organs are removed from brain-dead donors. The analysis in this paper demonstrates that presumed consent, as it is being practiced currently, is not a consent but a fiction. *Presumed consent (and therefore, the opt-out system) would be valid only if the public were to be fully informed about the factual reality of what ‘brain death’ truly is.* A review of the historical events, and the manuscript-drafts of the Harvard Report, brings to light the inherent utilitarian link between the interests of transplantation and the introduction of ‘brain death’ in 1968. ‘Brain death’ is not true death but a medico-legal construct whereby deeply comatose patients (deemed to be in irreversible coma) are declared...
dead so that organs can be legally removed. Therefore, before introducing any opt-out legislation on organ donation, the State must first fulfill its duty to inform its citizens that they would not be dead yet when organ procurement begins, and that, in fact, they would be killed by the process.

**Zusammenfassung**

Hirntod, Organspende und die angenommene Zustimmung – Eine Zustimmung kann nicht angenommen werden, da der „Hirntod“ nicht der wirkliche Tod ist


Der „Hirntod“ ist nicht der wirkliche Tod, sondern ein medizinisch-rechtliches Konstrukt. Durch dieses medizinisch-rechtliche Konstrukt werden die tiefkomaoten Patienten (die als irreversibel gelten) für tot erklärt, damit ihre Organe legal entfernt werden können. Bevor der Staat eine Widerspruchsgesetzgebung (Opt-out- Gesetzgebung) für die Organspende einführt, muss er daher zunächst seine Informationspflicht erfüllen: Der Staat muss also seine Bürger darüber informieren, dass sie als Organspender noch nicht tot sein werden, sondern erst durch den Prozess der Organentnahme getötet werden.
1 Introduction

The debate on organ donation-transplantation once again returned to the spotlight of sociopolitical life in Germany when, at the beginning of September 2018, Jens Spahn, the Health Minister, introduced a draft bill in order to push Germany to “change its laws on organ donation and adopt an opt-out scheme to increase the number of organs available for transplantation.” The reason for Spahn’s intervention is self-evident: the persistent decline in organ donation in Germany. According to the data on ‘postmortem’ organ donation from the Deutsche Stiftung Organtransplantation (German Organ Transplantation Foundation), the number of organ donors has dropped from 1296 donors in 2010 to only 797 in 2017 (i.e., from 15.9 to 10.4 donors per million inhabitants), which in turn resulted in 1500

---

1.“German Health Minister Calls for Opt-out Organ Donation,” Deutsche Welle http://www.webcitation.org/76mIdDER0.

2.The term ‘postmortem’ is written with quotation marks because, as will be shown further in this paper, the ‘brain death’ paradigm for the determination of death (and thus, the source of ‘postmortem’ organ donation in Germany) has been proven to be seriously flawed as it contradicts the reality of biological (medical) evidence, the sound tenets of philosophical anthropology, and the principles of holistic contemporary biophi-losophy. For an exhaustive treatment on the indefensibility of ‘brain death,’ see Doyen Nguyen, The New Definitions of Death for Organ Donation: A Multidisciplinary Analysis from the Perspective of Christian Ethics (Bern: Peter Lang, 2018). Similarly, the term ‘brain death’ is also written with quotation marks, because it is a condition in which, in the great majority of cases, neither the patient nor his or her brain is dead.
fewer life-saving organ transplants in 2017 than in 2010.\(^3\) Furthermore, in spite of 2,594 transplants performed in 2017, there were still 10,000 patients on the waiting-list as of the end of August 2018.\(^4\) The draft bill introduced by Spahn was approved by the German federal government at the end of October 2018. At this writing, whether or not the bill will become law depends on the decision of the Bundestag (the German federal parliament) in 2019.\(^5\)

Similar to other developed countries, the main source of organ donation in Germany consists of heart-beating donors, i.e., individuals pronounced dead based on neurological criteria, also referred to as the ‘brain death’ paradigm. However, ‘brain death,’ despite its worldwide acceptance as a legal policy, has been the subject of unrelenting controversy since its inception such that today “doubt [regarding ‘brain death’] has become an international consensus.”\(^6\)

Nevertheless, according to the current opt-in policy for organ donation in Germany, before any organ donation can take place in Germany, the following must happen:

- A patient must have severe, irreversible brain damage


\(^4\)Alice Tidey, “Germany Debates Opt-out System for Organ Donations,” Euronews http://www.webcitation.org/76mm5arUd.


and be considered a potential organ donor.

- The treating physician must recognize this situation in timely fashion and report it to the DSO [Deutsche Stiftung Organtransplantation].

- The patient’s irreversible loss of brain function must be ascertained and documented.

- The patient must truly be suitable for organ donation.

- Consent to organ donation must be present.\(^7\)

Germany is not the only country to struggle with the chronic shortfall of human organs for transplantation. The widening gap between demand and supply, which results from a combination of complex factors, has remained a problematic issue in many developed countries, some of which (e.g., Austria, Belgium, and France) have sought to expand the donor pool by means of opt-out legislation.\(^8\) If the bill proposed by Spahn is passed by the Bundestag in 2019, organ donation in Germany will switch from its current opt-in policy (which requires explicit consent) to an opt-out system, frequently also referred to as presumed

---

\(^7\)Schulte et al., “Decline in Organ Donation in Germany,” 465.

consent. Independent of the ‘brain death’ controversy, presumed consent is itself also a subject of serious debate, however.\textsuperscript{9}

In other words, the current debate on organ donation in Germany touches on both the ‘brain death’ and presumed consent controversies at once, which in turn raises two separate yet interrelated ethical questions. The first question is: can consent be presumed? Stated differently, is presumed consent indeed a consent, or is it a fiction? The second and more important question is: are brain-dead donors dead? Stated differently, is ‘brain death’ true human death, the biological manifestation of which is the loss of somatic integration, or is it a construct for the purpose of organ transplantation? In examining both of these issues, the aim of this paper is two-fold. First, the paper will show that, regardless of its practical benefits to organ donation-transplantation, presumed consent (the basis for the opt-out legislation) raises a whole host of difficulties. In particular, it is philosophically indefensible because it is nothing more than a hypothetical consent, and therefore, not a consent as such. Second, the paper will show

that, in addition to its known biological inaccuracies and philosophical incoherences, \textsuperscript{10} ‘brain death’ since its inception has been a construct designed to serve the ends of transplantation. The paper thus seeks to bring to light the utilitarian character of both the opt-out policy and the ‘brain death’ paradigm with respect to its genesis. If they are combined together and act synergistically, what would be the moral consequences to the society even if, for the time being, such consequences still remain carefully hidden from the general public?

2 On Consent in Organ Donation

On the one hand, it has been hailed that “organ and tissue donation to others symbolizes the greatest goodness of a person – the capacity to make other’s lives better.”\textsuperscript{11} In this regard, a vigorous appeal to noble charity and solidarity, frequently in conjunction with the use of the catchphrase ‘the gift of life,’ has been one of the most common strategies for promoting organ donation.\textsuperscript{12} The Catholic

\textsuperscript{10}See Nguyen, \textit{The New Definitions of Death for Organ Donation}. 
\textsuperscript{12}See Nguyen, \textit{The New Definitions of Death for Organ Donation}, 516.
Church, especially through the words of Pope John Paul II, also sees organ donation as a new way for man to make a sincere gift of himself and fulfill his “constitutive calling to love and communion.” Moreover, in the eyes of the Pope, the gift of a vital organ donated after death gives the donors the possibility “to project beyond death their vocation to love.” The same teaching is found in the Catechism which states: “Organ donation after death is a noble and meritorious act and is to be encouraged as an expression of generous solidarity.” At the same time, however, Catholic moral tradition also emphasizes that ‘post-mortem’ organ donation “is not morally acceptable if the donor or his proxy has not given explicit consent.”

On the other hand, as pointed out by Sneddon, it cannot be denied that at the very core of organ donation, “the most fundamental reason to acquire organs at all is utility. If people could not benefit from available organs, or if we were unable to use organs to help people, then we would not have such practices.” This rationale of utility is operative in every legal system which regulates the pro-

---

14 Ibid., no. 4.
15 Catechism of the Catholic Church (Vatican City: Libreria Editrice Vaticana, 2003), no. 2296.
16 Ibid.
curement of ‘postmortem’ transplant organs, irrespective of whether it follows the opt-in or opt-out policy. The first is based on explicit consent; the second, on presumed consent. For the sake of clarity, the ‘brain death’ controversy, which will be treated in section 3, is bracketed out from the discussion on consent presented below.

In countries which follow the opt-in legislation such as Germany and the United States, the basic rule is that the procurement of ‘postmortem’ organs can be performed if there is explicit permission on the part on the patient who, during life, has agreed to organ donation. This is reflected in such documents as the donor registration card, driver’s license, or some other form of advanced directive. In the absence of any such explicit decision, no organ removal can take place unless the patient’s family or a person whom the patient had designated as a proxy, consents to donate the patient’s ‘postmortem’ organs. In contrast, under a presumed consent legislation, the newly deceased (namely, the brain-dead patient) whose organs are deemed suitable for organ harvesting is automatically considered to be a donor unless he or she had registered his or her objection to opt-out from organ donation. In the absence of any such explicit objection, it is presumed that the individual would have allowed the removal of his or her ‘postmortem’ organs. In other words, in the pure opt-out policy, the default when the patient had not made any decision during his life, is to proceed with organ removal whereas in the opt-in system, the default is not to proceed. In real life, the practice of opt-out policies varies between countries, ranging from ‘hard’ to ‘soft’ depending on the extent to which the views of the relatives are taken into account.
when the donor had not registered his or her objections.\textsuperscript{18} According to the argument of supporters of opt-out legislation, presumed consent “mak[es] it easier for the family not to oppose donation and free[s] them of any responsibility or remorse,” whereas the opt-in policy puts the burden of the responsibility on the family, already distraught by the death of their loved ones.\textsuperscript{19}

\section*{2.1 The Personalistic norm, the Ethical Foundation of Consent}

From an ethical viewpoint, the term ‘consent’ refers to the act of giving a permission, an approval, or an agreement. To be valid, a consent must be given freely, without coercion or deception. Consent necessarily presupposes a moral agent with sufficient mental capacity to give it. The notion of consent in organ donation is derived from the practice of informed consent in other medical fields, either those which involve diagnostic or therapeutic procedures to be performed on patients, or clinical research involving human subjects.

The notion of consent is founded on the ethical principle of respect for persons which is an expression of the person-

\begin{footnote}{\textsuperscript{18}An example of ‘soft’ opt-out policy is Italy, where organ removal can proceed once it has been ascertained that the family does not object. An example of ‘hard’ opt-out policy is Austria where relatives have no say at all. See Kennedy et al., “The Case for ‘Presumed Consent’ in Organ Donation,” 1650.}

\begin{footnote}{\textsuperscript{19}Constantinos Simillis, “Do We Need to Change the Legislation to a System of Presumed Consent to Address Organ Shortage?,” \textit{Medicine, Science and the Law} 50, no. 2 (2010): 84-94, 89.}

\textsuperscript{18}An example of ‘soft’ opt-out policy is Italy, where organ removal can proceed once it has been ascertained that the family does not object. An example of ‘hard’ opt-out policy is Austria where relatives have no say at all. See Kennedy et al., “The Case for ‘Presumed Consent’ in Organ Donation,” 1650.

\textsuperscript{19}Constantinos Simillis, “Do We Need to Change the Legislation to a System of Presumed Consent to Address Organ Shortage?,” \textit{Medicine, Science and the Law} 50, no. 2 (2010): 84-94, 89.
alistic norm. This norm, operative in all spheres of human life, “states that the person is the kind of good which does not admit of use and cannot be treated as an object of use and as such the means to an end ... [Stated differently,] the person is a good towards which the only proper and adequate attitude is love.”[20] When applied to the realm of medicine and science, the personalistic norm basically means that the interests of individuals prevail over those of science and society. Here, it is worth recalling that, already in 1845, Max Simon, a French physician, emphasized this ethical position in the following words: “one cannot not stress this principle enough: the most indigent patient, even as the most useless to society, cannot be subjected to experiments that could endanger his life. Perish rather science than such principle!” [my translation].[21] It may be argued that this ethical position does not apply to organ donation since it is not a medical experiment on human subjects, but rather a ‘postmortem’ procedure. However, such an argument would be valid only if ‘brain death’ criteria were both empirically (biologically) and theoretically (philosophically) sound, which they are not, as has been amply proven in the published literature.

The same insistence on the personalistic ethical principle


is echoed in the teaching of the Catholic Church, notably, through the insightful words of Pope Pius XII. In his 1952 Address to the First International Congress on the Histo-pathology of the Nervous System, Pius XII taught three important points: (i) science is not the highest value to which all other values should be subordinated; (ii) the human person is not ordained to be an object of utility to the society; on the contrary, the community is to be there for man, instead; and (iii) man is not the absolute master but only the steward of nature, including his own body; hence, he cannot freely dispose of himself as he pleases. This means no one, not even the individual him- or herself, “may treat either his or her body, or the organs as property that can be taken and distributed at will.”

22See Pius XII, “Discours aux Participants au Congrès International d’Histopathologie du Système Nerveux (14 September 1952)” http://w2.vatican.va/content/pius-xii/fr/speeches/1952/documents/hf_p-xii_spe_19520914_istopatologia.html (accessed 01/17/2018). The Pope’s original statement in French is as follows: “la science n’est pas la valeur la plus haute, à laquelle tous les autres ordres de valeurs – ou dans un même ordre de valeur, toutes les valeurs particulières – seraient soumises. […] L’homme dans son être personnel n’est pas ordonné en fin de compte à l’utilité de la société, mais au contraire, la communauté est là pour l’homme. […] En ce qui concerne le patient, il n’est pas maître absolu de lui-même, de son corps, de son esprit. Il ne peut donc disposer librement de lui-même comme il lui plait.”


in ‘postmortem’ organ donation.

Independent of the Church’s teaching, the principle of respect for persons has also been the cornerstone and foundation of secular medical ethics. As pointed out by Harris, respect for persons entails both: (i) respect for autonomy and, therefore, respect of the patient’s autonomous choices; and (ii) concern for his or her welfare. This last dimension reflects the known principles of beneficence and non-maleficence with respect to the consenting subject, both of which cohere with the principle *primum non nocere* of the Hippocratic Oath.

### 2.2 The Lack of Transparent Disclosure to the Public about ‘Brain Death’

At first glance, it seems that both the opt-in and opt out systems uphold the respect for persons since, as Hartogh points out, “systems of both types purport to respect the decision of the deceased person, whether his decision is to donate or to refuse donation, or to hand over the decision to his relatives (or to some other person [who acts as a proxy]).” As shown below, a close look at the practice of organ donation reveals that respect for persons is lacking in both systems.

That both opt-in and opt-out systems respect the decision of the deceased person (or, alternatively, of the family or

---


the proxy) necessarily presupposes that people have been substantially and honestly informed about all the crucially relevant facts regarding organ donation such that they can have an adequate understanding of the consequences of their decisions. In this regard, the crucial question that must be considered is the following: in the current practice of organ donation, how much of the relevant information about ‘brain death’ has been provided to the public at large? Put differently, do individuals in the opt-in system who have agreed to the ‘postmortem’ removal of their organs, and individuals in the opt-out system who have not registered their refusal to donate, understand what the state of ‘brain death’ is? Have they been provided sufficient information to know that ‘brain death’ is not death as ordinarily understood, i.e., not in the sense as when one speaks of the death of a family pet? The answer to this question is ‘no’ because even in the purported informed consent of the opt-in policy for organ donation,

“For most people, the understanding about organ donation is limited to the consent forms filled in at their state Department of Motor Vehicles, or online at their regional Organ Procurement Organization websites. The information provided on such websites is unidimensional, geared toward promoting donation and reinforcing consent. In particular, there is no mentioning of any other options for end-of-life care (e.g., hospice). In that sense, it is difficult to say that the average lay person is fully informed when he/she signs the informed consent
for organ donation after death.”

The above remark is confirmed by the study by Woien et al. who, in a survey of 60 Organ Procurement Organizations (OPO) in the United States which handle online organ donation registration, found that:

“The disclosure on OPO Web sites and in online consent forms lacked pertinent information required for informed enrollment for deceased organ donation. [...] The Web sites predominantly provide positive reinforcement and promotional information rather than the transparent disclosure of the organ donation process.”

Similarly, in the United Kingdom where the government is transitioning from the existing opt-in to an opt-out policy, it has been found that:

“The process of registration with the ODR [Organ Donor Register] falls well short of that required to establish informed consent. The educational materials associated with the ODR consist of information designed to encourage donation, with no mention of possible negative consequences of participation in donation.”

---

28 Dale Gardiner and Robert Sparrow, “Not Dead Yet: Controlled
Put bluntly, the OPO and ODR function more as advertisements at the service of organ transplantation rather than as “reliable sources of information about the relevant facts surrounding the organ donation process.” Thus, under the opt-in system, the lack of transparent disclosure of the crucially pertinent information concerning ‘brain death’ and organ harvesting leads people to give explicit consent without substantial understanding of the issue at hand. Hence, their explicit consent is *de facto* not an informed consent. Likewise, under presumed consent (opt-out) legislation, the same lack of transparency deprives people from the possibility of registering their objection to donating organs. Where can they find, without great difficulty, the information that, if they were to be declared brain-dead: (i) their heart would still continue to beat spontaneously, (ii) they may still retain some brain activity, in particular, the production of antidiuretic hormone by the posterior pituitary–hypothalamus axis, (iii) very likely, they would still have spontaneous movements and spinal reflexes, and (iv) there would be increased heart rate and

---


blood pressure in reaction to skin incision and sternotomy at the time of organ removal\(^{32}\). Without important information of this kind, people will not see why they need to take time to register their objection to donating their organs ‘postmortem.’ In the unforeseen case of being declared brain-dead, they would fall into the default category, except in the ‘soft’ opt-out system where the family is allowed to express their objection.

Where the family is involved because of the absence of any explicit decision on the part of the brain-dead patient, it is unlikely that the relatives are provided the crucially relevant information about ‘brain death’ and organ removal. The reason for this is at least threefold. First, the complexity of the ‘brain death’ controversy is such that “many physicians do not understand the conceptual difficulties, inadequacies, and fallacious reasoning surrounding the brain death doctrine;”\(^{33}\) hence it is doubtful that they

\[\text{Journal of Neurological Sciences} \ 36, \text{no. 2 (2009): 154-160. According to this review, the occurrence of spontaneous movements and reflexes can be observed in 75-80\% of brain-dead patients, especially during the first 24-72 after the declaration of ‘brain death.’ Reflexes can occur in response to some painful or noxious stimuli (including hypoxia or hypotension during the apnea test). Movements range from simple reflexes such as deep tendon reflexes and plantar flexor response, to complex movements, the most dramatic of which is the Lazarus sign.}\]

\[\text{32See Randall C. Wetzel et al., “Hemodynamic Responses in Brain Dead Organ Donor Patients,”} \ \text{Anesthesia and Analgesia} \ 64, \text{no. 2 (1985): 125-128; Eelco F. M. Wijdicks, “Determining Brain Death in Adults,”} \ \text{Neurology} \ 45, \text{no. 5 (1995): 1003-1011.}\]

\[\text{33Nair-Collins, “Death, Brain Death, and the Limits of Science,”} \ 677.\]
can explain the matter clearly to the family. Second, it cannot be expected that transplant coordinators, OPO personnel, or pro-‘brain death’ physicians (if they happen to handle the care of severely brain injured, deeply comatose patients) would offer the family an unbiased picture on ‘brain death’ and organ donation. Rather, in all likelihood, they will seek to skillfully persuade the distraught family into consenting to the removal of the organs of the brain-dead person. The relatives see that their loved one (connected to a ventilator and receiving pharmacological support) is warm and pink, with the heart still beating; yet, at the same time they are told, with no uncertainty, that their loved one is already dead. Their experience is one of cognitive dissonance which further compounds their grief and distress. It is in such vulnerable moments that the request for organ retrieval is posed to the relatives. Incorporated in the request is a subtle nudging strategy which invariably appeals to noble charity and solidarity, along with the exhortation that organ donation is “a way of finding meaning in death [by] mak[ing] the best of a tragic situation,” and that the family “can [find] consolation in the fact that some concrete good has come of their loss.”

transparency are the benefits (e.g., research grants) offered to medical institutions and hospitals which promote organ donation-transplantation.\footnote{In this regard, it is of note that in Germany, the bill drafted by Spahn, the Health Minister, includes the plan that “some 1,300 hospitals where transplantations are performed would receive a higher remuneration.” See Pearson, “Germany Proposes Law to Increase Organ Transplants.”}

To sum up, in the current climate of organ donation, the lack of transparent disclosure of the crucial information about ‘brain death’ to the public at large basically interferes with people’s ability to act as autonomous agents. Put simply, it directly contradicts respect for autonomy and, therefore, the personalistic norm. Moreover, the default is far worse in the opt-out than the opt-in system since, in the absence any clear decision of the individual during life, the former proceeds with organ removal whereas the latter does not. What then is the motive why so many European countries have adopted the opt-out legislation? Even more important, however, is the following question: if, as shown above, explicit consents (whether from the donors or their families) for organ removal under the opt-in legislation are not informed consent, then in what way can presumed consent qualify as a consent? Or put simply, is the concept of presumed consent defensible?

2.3 On Presumed Consent: Why Consent for Organ Procurement Cannot Be Presumed

At first glance, the idea of presumed consent seems to be commendable because it seeks to reduce the loss of lives of patients on the waiting list who could have been saved through organ transplantation. For the sake of the argument, let us take the term ‘postmortem’ for what it literally means, that is, after death. This in turn requires that one must consider what death is.

2.3.1 Pope Pius XII’s Teaching on Postmortem Organ Donation

Metaphysically speaking, a human person is the union of body and soul. Death is the metaphysical event marked by the separation of the soul from the body which now becomes a corpse (a cadaver). To be specific, a cadaver, precisely because it is a non-ensouled body, is a body in name only, just as the eyes of the statue of a person are eyes in name only. Thus, a cadaver, a dead ‘body,’ does not have the status of a person but rather, that of a res (a thing, an object). From a purely physicalist perspective, which sees the corpse only in terms of its material composition, this is true. A res is not a bearer of rights or a member of the moral human community to whom certain

---

protections apply, namely, “the prohibition of autopsies, burial, or cremation while still biologically living.”

However, does this mean that it can be eviscerated without the permission of the individual (while still alive) or of the relatives now in charge of his mortal remains? Here, the insightful teaching of the Catholic Church, expressed through the words of Pope Pius XII in one of his discourses in 1952, sheds light on why a human corpse deserves to be treated differently from an animal corpse. The Pope stated: “the [dead] body was the abode of a spiritual and immortal soul, [it was] an essential and constitutive part of a human person whose dignity it shared; something of that dignity still remains in it” [my translation].

In other words, a human dead body has an intrinsic moral and religious dimension attached to it. This is why, as Pius XII reiterated in the conclusion of the same discourse, doctors cannot just extract organs from the deceased for therapeutic (i.e., transplantation) purposes as they please, without taking into account the rights of those in charge of the body of the deceased, that is, without informed consent. It should

---

39 Pius XII, “Discours à L’association des Donneurs De Cornée Et à L’union Italienne des Aveugles (14 May 1956)” http://w2.vatican.va/content/pius-xii/fr/speeches/1956/documents/hf_p-xii_spe_19560514_cornea.html (accessed 01/17/2018). The original French text reads: “Le corps était la demeure d’une âme spirituelle et immortelle, partie constitutive essentielle d’une personne humaine dont il partageait la dignité; quelque chose de cette dignité s’attache encore à lui.”
40 Ibid. At the end of his address, Pius XII stated in French: “En
be noted here that the teaching of Pope Pius XII reflects a deep understanding of human psychology, recognizing the fact that most cultures and religions have always treated the dead with reverence, that is, as ends in themselves, rather than as means to an end. As attested to by Baumann et al.,

“Even under a regimen of presumed consent many families feel naturally entitled to defend their dying or dead loved one’s physical and spiritual interests and speak on his or her behalf. Certainly, posthumous harm could occur when the patient’s own wishes or values are not looked for, are disregarded or not respected. Moreover, families also can be harmed, especially by overlooking the affective or family bond by denying them the right to express, honour and put into practice the values of their departed beloved. So, presumed consent is often viewed by families with much suspicion.”

2.3.2 The Utilitarian and Presumptuous Character of Presumed Consent

Corresponding to the above metaphysical understanding of human death is the ordinary common sense understanding of death which recognizes that, in its concrete manifestation,

“Death is a biological phenomenon and should apply equally to related species. When we talk of the death of a human being, we mean the same thing as we do when we talk of the death of a dog or a cat. This is supported by our ordinary use of the term death, and by law and tradition. It is also in accord with social and religious practices and is not likely to be affected by future changes in technology.”

If indeed the ongoing debate about ‘postmortem’ organ donation refers to death understood in its ordinary sense as stated in the above-quoted passage, and if one also brackets out (or is unaware of) the above-mentioned teaching of the Church, then one may think that the idea endorsed by advocates of opt-out legislation makes good sense. From their perspective, when a person dies, his or her dead ‘body’ is a res; the organs are no longer useful to that person, but they can save the lives of patients with organ failure; therefore, ‘postmortem’ organs must be made available in a way

---

that maximizes the benefits of living patients awaiting organ transplants. In this vein, some ethicists have even argued that the refusal to donate one’s ‘postmortem’ organs, thereby wasting them through burial or cremation at the cost of other people’s lives, is effectively “morally unacceptable” because it puts the interests of the dead above those of living persons.

It is thus clear that the fundamental premise upon which rests other various arguments for presumed consent legislation, is the utilitarian motive that “any measure that increases the supply of organ transplantation is a good thing.” This is why advocates of the opt-out policy frequently appeal to studies which compare the organ donation-transplantation between opt-in and opt-out countries, showing that the presumed consent legislation is associated with a higher rate of organ donation. This does not mean, however, that there is a causal relationship between pre-

---


sumed consent and increased donation, since such stud-
ies often do not take into account “complementary and/or
supportive factors that could be attributed alongside in-
troduction of presumed consent (e.g., publicity campaigns,
organizational change, [and] infrastructural support).” A
case in point in this regard is Spain where the opt-out le-
agislation, introduced in 1979, has nevertheless remained
dormant as evidenced by the absence of an opt-out re-
gistry. As Murphy and colleagues point out, the “Span-
ish law is a theoretical presumed consent, but in practice
the system is ‘opt-in.’

Spain’s record of being the country with the highest rate
of organ donation (34-35 per million inhabitants) obtained
primarily from brain-dead donors, relies primarily on in-
frastructural measures, especially transplant coordinators,
most of whom are intensive care physicians or anesthesiolo-
gists charged with the special task of identifying potential
donors. Under such a practice, however, what is the like-
lihood that a severely brain-injured and deeply comatose
patient would be left to progress to a stage where he or she
would be declared brain-dead instead of receiving aggress-
ive neuro-intensive care which could bring him or her to

46 Adnan Sharif, “Presumed Consent Will Not Automatically Lead
to Increased Organ Donation,” *Kidney International* 94, no. 2 (2018):
249-251, 249.

47 See Paul Murphy, Rafael Matesanz, and John Fabre, “Presumed
Consent Is Unnecessary,” *British Medical Journal* 341, no. 7779

48 Ibid., 922.

49 See Rafael Matesanz, “Factors Influencing the Adaptation of the
Spanish Model of Organ Donation,” *Transplant International* 16, no.
recovery, even if partial? It would be naïve to think that a physician who is pro-‘brain death’ will handle the severely brain-injured, deeply comatose patient in the same way as a physician who is not. For the patient, his or her outcome – life or death – may come down to whether he or she “is anticipated as a potential organ donor or whether he or she is viewed as a patient who deserves the maximum therapeutic intervention with a view to full recovery.”

Advocates of opt-out legislation also appeal to the data of poll surveys which have indicated that the public supports organ donation. In the United States, the well-known Gallup survey in 1993 showed that 69% Americans were favorable to donating their organs ‘postmortem,’ yet only 28% actually indicated their explicit consent on their donor card or driver’s license. The same phenomenon is observed in Germany where, in the 2014 survey by the Bundeszentrale für gesundheitliche Aufklärung (Federal Center for Health Education) 71.0% of the respondents indicated they would donate their organs, whereas only one

50 An example of this sad truth is Coimbra’s account of a 15 year-old brain injured female patient who was declared brain-dead without having received aggressive neuro-intensive therapy during the precious 48-72 hour time window after the initial injury. See Cicero G. Coimbra, “Are “Brain Dead” (or “Brain-Stem Dead”) Patients Neurologically Recoverable?,” in Finis Vitae: “Brain Death” Is Not True Death, ed. Roberto De Mattei and Byrne Paul A. (Oregon, Ohio: Life Guardian Foundation, 2009), 313-314.


third of them carry an organ donor card.\textsuperscript{53} Similarly in the United Kingdom, “over 80% of the adult population say they would definitely, or would consider, donating their organs, but only 37% of the population have registered as donors on the NHS [National Health Service] Organ Donor Register.”\textsuperscript{54} On the basis of this kind of data, it has been argued that opt-out legislation would improve organ donation rates and reflect better the wishes of the society because presumed consent is grounded in “the recognition of the unexpressed but autonomous will of most members of society. […] Hence], it would be safe to assume that people who have not registered an objection want to donate their organs.”\textsuperscript{53} Such an argument is seriously flawed, because it is based on the false assumption that, because most people approve organ donation, one may presume that they actually want to donate their organs. Such an assumption is unfounded as it overlooks several common sense facts


\textsuperscript{54}“The Opt-out System,” NHS https://www.organdonation.nhs.uk/ supporting-my-decision/the-opt-out-system/ (accessed 01/07/2019). After this paper was accepted for publication, the UK voted to change to an opt-out system effective spring 2020 and has changed their website. Similar data can be found in Simillis, “Do We Need to Change the Legislation to a System of Presumed Consent to Address Organ Shortage?,” 89.

of life, such as: (i) polls can be inaccurate since what a person gives as a response to a survey does not warrant that he or she will act that way; (ii) the large gap between the support for organ donation and the actual registration to donate may very well indicate ambivalence, doubt and reluctance more than anything else on the part of those who have not registered.\footnote{G. C. Webster, “Presumed Consent? Let’s Not Be Presumptuous!,” Canadian Medical Association Journal 159, no. 2 (1998): 135. See also, T. Tottoczko, “Presumed Consent: What Does It Mean?,” Transplantation Proceedings 35, no. 3 (2003): 1195-1197, 1196; Hartogh, “Can Consent Be Presumed?,” 299.} Thus, it is rather presumptuous for supporters of an opt-out policy to assert that “it is permissible to use the organs of someone who did not opt out, because they have – by their silence – actually consented.”\footnote{B. Saunders, “Opt-out Organ Donation without Presumptions,” Journal of Medical Ethics 38, no. 2 (2012): 69.}

\subsection*{2.3.3 The Deceptive Character of Presumed Consent in Organ Donation}

The logic of presumed consent in organ donation totally differs from that used in emergency settings where informed consent cannot be obtained but life-saving procedures need to be initiated on the patient. It is morally right to proceed, however, because life-saving interventions under emergency conditions are “always governed by the principle of ‘the best interests’ of the patient, not some third party.”\footnote{M. D. Dominic Bell, “The UK Human Tissue Act and Consent: Surrendering a Fundamental Principle to Transplantation Needs?,” Journal of Medical Ethics 32, no. 5 (2006): 283-284.} Since
life is universally recognized by mankind as the highest good in the created world, it can be safely presume that the patient in question would have consented explicitly to have life-saving procedures performed on him or her. Thus, life-saving intervention is the paradigmatic exception in which the notion of presumed consent applies for the sake of the welfare of the person whose consent is being presumed.\textsuperscript{59} Such is, however, not the case with organ retrieval which serves the interests of some anonymous potential recipients rather than the welfare of those (i.e., the brain-dead patients) whose consent are being presumed. As such, presumed consent contradicts the principle of beneficence which is part and parcel with the notion of consent itself.\textsuperscript{60}

Most importantly, the notion of presumed consent for organ donation is philosophically indefensible, precisely because consent, properly understood, refers not to an intention or “a disposition to prefer or wish or desire that action be done . . . [but rather] a public act of authorization.”\textsuperscript{61} Most arguments for opt-out legislation invariably rest on the interpretation of consent as intention or disposition.\textsuperscript{62} This is a false understanding of consent, however, because an intention or disposition for a certain preference (in this


\textsuperscript{60}See the discussion at the end of section 2.1.

\textsuperscript{61}Hartogh, “Can Consent Be Presumed?,” 296. See also, Saunders, “Opt-out Organ Donation without Presumptions,” 71.

\textsuperscript{62}The usual claim is that the opt-out policy fulfills the wish of most people to donate since surveys have shown that most people support organ donation. See footnotes 49-51.
case, to donate one’s organs) is first-person knowledge or a mental state which no other party can have access to. The individual him- or herself must explicitly make it known to another person. Hence, consent is an action and not a mental state. This is why:

“The presumption of consent does not mean that it can be safely assumed that consent has been given. […] It only means that it can be assumed that people would consent under hypothetical circumstances. But hypothetical consent is no consent, anymore than false money is money, a potential donor (or person) is a donor (or person), or a shadow cabinet is a cabinet. Therefore presumed consent [for organ retrieval] is a fiction.”

If presumed consent is a fiction, then to adopt it as a policy and pass it as if were equivalent to actual consent would be ethically deceitful to the public. This would further compound the moral issues associated with the ‘brain death’ paradigm which currently supplies the bulk of transplant organs. Indeed, as to be shown below, the reality of what ‘brain death’ truly is, is the very reason why presumed consent legislation cannot be accepted.

---

63 Hartogh, “Can Consent Be Presumed?,” 299.
3 Organ Transplantation, the Direct Cause of the Genesis of ‘Brain Death’

A common argument advanced by scholars who not only support opt-out legislation but also recommend automatic “routine recovery of cadaveric organs” (i.e., mandatory organ donation), is the following: the necessity for obtaining consent applies only to the living and not to the dead because consent is designed to foster a person’s moral autonomy and protect him or her from harm and exploitation; but a corpse has neither autonomy nor interests, and therefore it cannot be harmed. Scholars supporting opt-out legislation and/or mandatory donation use the terms ‘cadaver’ and ‘cadaveric organs’ in reference to ‘brain-dead’ donors without giving any consideration to the protracted and heated controversy about ‘brain death.’ In other words, such scholars treat the patient as really dead when he or she is declared brain dead. But is ‘brain death’ truly death, that is, death as it understood in the ordinary sense of the term?

The answer to the above question is a resounding “no.”

---


65 See the block quote corresponding to footnote 42.
Numerous publications have already demonstrated that ‘brain death’ does violence to both the reality of the empirical medical evidence and the sound tenets of philosophical anthropology founded on classical Aristotelian-Thomistic metaphysics. Even Bernat, the staunchest defender of

'brain death' has to acknowledge that the ‘brain death’ paradigm is flawed. He nevertheless argues that it remains an optimal public policy for the organ procurement enterprise because “in the real world of public policy on biological issues, we must frequently make compromises or approximations to achieve acceptable practices and laws.” Bernat’s own words clearly reflect the utilitarian ends of the ‘brain death’ paradigm.

It is not the purpose of this paper to reiterate in detail the biological inaccuracies and conceptual flaws inherent in the ‘brain death’ paradigm. Suffice it to indicate, however, as attested in the passage below, that even intensivists (i.e., intensive care physicians) and anesthesiologists who are proponents of organ donation-transplantation recognize that,


68 Ibid.
“The bare fact that many brain-dead patients can continue to perform a variety of integrative functions over indefinite time periods, including maintaining body temperature, persistent and adequate hypothalamic hormonal function, regulating salt and water homeostasis, digesting administered food, healing wounds, increase of infection markers and healing infections, stress responses to bodily interventions such as surgery and gestating fetuses in pregnant brain-dead women, makes some wonder whether a brain-dead patient is as ‘dead’ as the doctors say. […] It is very difficult to see a ‘brain-dead’ pregnant woman, in whose womb a fetus grows over a time period for 2–3 months after the determination of brain death, as ‘a cadaver.’ There are just too many signs of life. Declaring these patients ‘dead’ solely on the basis of ‘a definition’ seems to contradict our common sense of what it is to be alive [italics added].”

The above-described clinical reality has been amply reported in the published literature on ‘brain death’ showing the irrefutable empirical evidence that brain-dead patients are not dead. Most notable in this regard is Shewmon’s large collection of well-documented cases of chronic ‘brain death’ survivors, one of whom survived for 20 years after

---

having been diagnosed brain-dead at age 4.\textsuperscript{70} There have been other cases since then, especially the recent famous case of Jahi McMath.\textsuperscript{71} Added to this are cases in which the patient (usually a young healthy teenager or young adult in deep coma due to severe traumatic brain injury) was assessed to be brain-dead, but who then somehow ‘miraculously’ recovered shortly before the scheduled organ harvesting and, as a result, narrowly escaped the lethal ordeal.\textsuperscript{72} Ironically, cases like these bring to mind Edgar Allan Poe’s short horror story on \textit{The Premature Burial}.\textsuperscript{73}

Thus, it is rather evident as pointed out by Kompanje that “without the needs of transplantation medicine, ‘brain


\textsuperscript{71}Very briefly, Jahi fulfilled the criteria for the determination of whole ‘brain death’ in December 2013 at age 13. Subsequently in mid-2014, she no longer fulfilled those criteria, that is, she was no longer brain-dead. This was attested by repeated laboratory studies and confirmed by four expert neurologists, including Alan Shewmon, and Calixto Machado (a ‘brain death’ proponent). For a detailed summary of this case, see Doyen Nguyen, Why the Thomistic Defense of ‘Brain Death’ is not Thomistic: an Analysis from the Perspectives of Classical Metaphysics and Contemporary Biophilosophy, \textit{The Thomist}, in press, footnote 27. See also D. Shewmon, “Truly Reconciling the Case of Jahi McMath,” \textit{Neurocritical Care} 29, no. 2 (2018): 165-170.

\textsuperscript{72}See Nguyen, “Brain Death and True Patient Care,” 260. See also, Erwin J. O. Kompanje, “Prognostication in Neurocritical Care: Just Crystal Ball Gazing?,” \textit{Neurocritical Care} 19, no. 3 (2013): 267-268.

\textsuperscript{73}Edgar Allan Poe, \textit{Complete Stories and Poems of Edgar Allan Poe} (Garden City, N.Y.: Doubleday, 1966), 261.
death as death’ would not exist at all. Yet ‘brain death’ proponents have insisted that the introduction of the ‘brain death’ paradigm into clinical practice was not prompted by organ transplantation but, rather, that it “owed its origin to the development of intensive care.” In particular, Diringer and Wijdicks, in defense of the Harvard Committee, have claimed “that the Ad Hoc Harvard Committee was primarily concerned with futility of care. [...] Facilitating transplantation was not a major objective [of the Harvard Report]. Organ donation as a potential consequence of this comatose state was not mentioned.” In the discussion which follows below, it will be shown that these claims are not true, and that indeed ‘brain death,’ from its very inception (i.e., even before the publication of the Harvard Report) has been specifically designed for the utilitarian purpose of obtaining fresh and viable organs for the transplantation enterprise. The evidence presented below is of two types: (i) external evidence, that is, the external events which led up to the formation of the Ad Hoc Harvard Committee, and (ii) more importantly, the internal evidence which was part and parcel of the genesis of the

3.1 Key External Events Leading up to the Formation of the Ad Hoc Harvard Committee

Three notable events set the stage for the Harvard Committee ‘brain death’ proposal: (a) the 1959 paper of two French neurologists, Mollaret and Goulon, (b) the 1966 Ciba Foundation symposium in London, and (c) the first heart transplants carried out by Barnard in 1967.

3.1.1 Mollaret and Goulon ‘le coma dépassé’ (irreversible coma)

In 1959, Mollaret and Goulon, reported a series of 23 patients with a ‘new’ type of coma characterized by complete unresponsiveness to any stimuli, absence of brainstem reflexes, lack of spontaneous breathing, muscle hypotonia, rapid progression of cardiovascular collapse, diabetes insipidus, altered thermoregulation, and a flat electroencephalogram which remained so until cardiac arrest. The authors designated this condition by the name ‘le coma dépassé.’

The same identical clinical features were to be described by the Ad Hoc Harvard Committee in 1968 as irreversible coma. In this regard, it is interesting to note that the Committee made no reference to the work Mollaret and Goulon

---

even though its members knew of the work, in particular Raymond Adams who “frequently spoke to Mollaret.”

The crucial difference between Mollaret and Goulon’s work and the Harvard report is that the former did not presume *le coma dépassé* (irreversible coma) to be true death whereas the latter did, as stated in its opening sentence: “*Our primary purpose is to define irreversible coma as a new criterion for death* [italics added].” Indeed, when Mollaret was asked the question “do we have the right to discontinue life support measures in the name of criteria which claim to draw a valid dividing line between life and death?,” his answer was, “facing these unfortunate patients who fulfill the criteria of what we have called *le coma dépassé*, I have not yet been able nor wanted to accept the *pollice verso* [thumb down] sign” [my translation].

The contrast between the action of Mollaret and Goulon and that of the Harvard Committee with respect to the same

---


80 Ad Hoc Committee of the Harvard Medical School, “A Definition of Irreversible Coma,” 337.

phenomenon of irreversible coma raises the following serious question (see section 3.3): does changing the definition of death change the phenomenon of death into what we want it to be?

3.1.2 The Ciba Foundation Symposium on Ethics in Medical Progress

During the 1960s, “the burgeoning field of organ transplantation unleashed a strong desire to expand the recipient pool.” Yet there were several impediments, notably the limited availability of living related donors and the poor quality of organs from cadaveric donors. Thus, at the 1966 international symposium on Ethics in Medical Progress: With Special Reference to Transplantation sponsored by the Ciba Foundation in London, one of the main issues on the agenda concerned the definition of death. As pointed out by Rothman, “the issue needed to be confronted in order to increase the efficacy of the transplant procedure,” especially since with the traditional determination for death, the kidneys (and other organs) deteriorate rapidly when deprived of blood supply upon the cessation of circulation due to cardiopulmonary arrest. Here, it should be noted that prior to 1968,

“[The] definitions of death found in various med-

\[82\] Diringer and Wijdicks, “Brain Death in Historical Perspective,” 6.
\[83\] Ibid., 7.
ical dictionaries and encyclopedias revolve around one central theme: the *cessation of all vital functions of the human body*. In formulating the criteria for determining death, these traditional medical definitions do not isolate the function of any one organ; rather, they emphasize the total stoppage of all vital bodily functions, [...] as evidenced by absence of heartbeat and respiration, [...] beyond the possibility of resuscitation. These classical medical definitions of death give no special significance to the vital function of the brain, [rather, they] place *the definition of death on an integrated basis*, stressing the idea of total stoppage of bodily functions [italics added]."⁸⁵

In other words, the above passage indicates that the traditional definition of death, which corresponds to the ordinary sense of death, reflects a holistic vision of human beings in which the human person is not reduced to the mind, and then further reduced from the mind to the brain.

At the above mentioned Ciba Foundation-funded symposium, intense discussions were held concerning the issue of equating *le coma dépassé* with death for the purpose of organ procurement. As the terminology ‘brain death’

---

or ‘brain-dead donor’ was not yet invented, labels such as ‘heart-lung preparations’ or the oxymoron terminology ‘living cadavers’ were used to refer to such potential donors. In particular, based on Mollaret and Goulon’s article, the Belgian surgeon Guy Alexandre advanced five neurological criteria for death which he had already applied since June 1963 on “patients with head injuries, whose hearts had not stopped, to do kidney transplantations.” There were participants favorable to Alexandre’s proposal for ‘brain death,’ although they would not have it applied to themselves or their family members. The one person who endorsed Alexandre’s idea most enthusiastically was Joseph Murray, a future member of the Harvard Ad Hoc Committee. “Those criteria are excellent,” he stated, “this is the kind of formulation that we will need before we can approach the legal profession.”

However, there was also strong opposition against Alexandre’s approach as several participants, in refuting the above statement of Murray, affirmed that “if a patient has a heartbeat he cannot be regarded as a cadaver.” In particular, David Daube, a professor in Civil Law, reiterated

88.“General Discussion,” Ethics in Medical Progress, 153.
that,

"Under the classical definition of death, which should not be lightly discarded, an irreversibly unconscious person whose life depends on a machine is still alive. The doctor may be right to stop the machine and let him die. But until death occurs, interference with his body is illicit: it is not a corpse."\(^{90}\)

Thus, the Ciba Symposium closed without reaching any agreement whether death should be redefined or not. The symposium itself was clear evidence, however, that the interests of organ transplantation played a causal role in the subsequent 'reclassification' of irreversible coma as death through the clever invention of a new name, ‘brain death.’

### 3.1.3 Barnard’s ‘Sensational’ Heart Transplantation

The movement toward redefining the criteria for death, which had begun with the need for better quality kidneys, took an accelerated turn with heart transplantation. The close temporal sequence between the Harvard Committee and Barnard’s pioneering heart transplant cannot be considered a mere coincidence. On December 3, 1967, in Cape Town, Christiaan Barnard conducted the first heart transplant taken from a young woman already declared dead.

(albeit with a beating heart) by a neurosurgeon. In order to avoid the criticism that he had killed the donor, Barnard did not remove her heart until the electrocardiogram had shown no activity for 5 minutes. Although the recipient “died 18 days later from extensive bilateral pneumonia,” this limited success was hailed throughout the world as a major medical triumph; thus allowing Barnard to proceed with a second heart transplant within less than a month. The second recipient lived for 18 months, with a questionable quality of life, however. Precisely because heart transplants had become a reality, “medicine urgently needed a new standard of death, specifically brain death, to determine when organs could be removed from a still-living body.” As a result, on January 4, 1968, Robert Ebert, the dean of Harvard Medical School approved the formation of an ad hoc committee in response to an earlier request from Henry Beecher. According to

94Gregory E. Pence, Classic Cases in Medical Ethics Accounts of Cases That Have Shaped Medical Ethics, with Philosophical, Legal, and Historical Backgrounds (Boston: McGraw-Hill, 2004), 44.
95On October 30, 1967, Beecher wrote to the dean of Harvard Medical School, Robert Ebert: “Both Dr. Murray and I think the time
the dean’s letter, the purpose of the Harvard Committee is to study “the ethical problems created by the hopelessly unconscious man [. . . and] the necessity of giving further consideration of brain death [. . . since] many of the ethical problems of transplantation and other developing areas of medicine hinge on appropriate definition.”

3.2 The Genesis of the Harvard Report

The Harvard Committee consisted of 13 members including one lawyer, one historian, one theologian (a Presbyterian minister), and ten physicians with expertise in transplantation, neurology, neurosurgery, public health, and anesthesiology (Beecher, the chairman of the Committee). The Committee worked swiftly behind closed doors from March through June and completed its work with the sixth has come for a further consideration of the definition of death. Every major hospital has patients stacked up waiting for suitable donors.” Note that the dean did not reply to Beecher immediately; the response only came after the news of Barnard’s acclaimed heart transplant. Beecher’s letter to dean Ebert is part of the ‘Beecher manuscripts’ preserved at the Francis Countway Library of Medicine at Harvard. Currently the records are closed to the public; they are made available only to certain selected people. Beecher’s letter is quoted in Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, 160-161.


97 In the original publication of the Harvard Committee’s report in 1968, the names of the Committee members were not made available. The reprint of the article, which appeared in the International Anesthesiology Clinics 45, no. 4 (2007): 113-119, listed all 13 members.
and final draft submitted to the dean on June 25, 1968. It received immediate publication on August 5, 1968.

3.2.1 The Harvard Committee’s Alleged Justifications for Identifying Irreversible Coma (‘Brain Death’) with Death

The Committee stated the reason for its work in the very first paragraph of the report as follows:

“Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation [italics added].”

---


99 Ad Hoc Committee of the Harvard Medical School, “A Definition of Irreversible Coma,” 337.
On the one hand, the Committee’s opening statement appears candid and forthright, assuring the reader that its first concern is the burden posed by the ‘irreversibly’ comatose patients to themselves and their families, and that this concern precedes the need to free up some beds in the intensive care unit. Organ transplantation, so it seems, was not the main impetus for the Committee’s definitional effort; only two references were made to transplant / transplantation in the entire report.

On the other hand, to advance irreversible coma (now with the novel label ‘brain death’) as the new criterion for the determination of death necessarily requires a philosophical rationale to explain why a patient in coma dépassé should be considered dead. Yet, as noted by various critics, no conceptual justification was provided in the Harvard Committee’s report. A post hoc philosophical rationale was not to come until the intervention of the President’s Commission in 1981. The two justifications presented in the opening paragraph pertain solely to the pragmatic and utilitarian order. However, are they sufficiently credible to

---

account for the necessity of introducing a new definition of death, that of identifying *le coma dépassé* with death?

First, it is difficult to see how the burden which patients in irreversible coma pose to themselves, their families, and hospital resources, could have required that a new definition of death be established. As Hans Jonas points out, the question is not whether the deeply comatose patient is dead, but rather how should such a patient be dealt with, that is, whether or not to discontinue the extraordinary measures of artificial life support and let the patient die naturally. Hence, “no redefinition of death is needed [… but rather] a redefinition of the physician’s presumed duty to prolong life under all circumstances.”

Most importantly, the decision to take the patient off life support must not be motivated by organ donation. Only then, and assuming that other ethical and medical prerequisites are met, one might accept that irreversible coma “is in itself sufficient ground to discontinue the extraordinary means of life support. Yet this does not necessitate calling this state death.”

Already before 1968, it had been part of the long-standing (though informal) medical tradition to quietly disconnect the ventilators of patients whose conditions were deemed terminal or irreversible, and to let the dying patient progress to natural death which would soon follow. Such a practice proves that “the discontinu-

---

103 Margaret M. Lock, *Twice Dead: Organ Transplants and the Re-
ation of extraordinary means of life-support (artificial respirators, etc.) could be justified without maintaining that irreversible breakdown of brain function is identical with death.\footnote{104} Furthermore, the Church’s teaching, namely the address of Pope Pius XII to anesthesiologists, also confirms that there is no absolute moral obligation to prolong at all cost the life of an irreversibly comatose patient whose clinical status steadily deteriorates.\footnote{105} Once natural death takes place in such patients, the need to free up ICU beds becomes a non-issue.

The Committee’s second justification states that the “obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation [italics added].”\footnote{106} It is unclear which controversy the Committee was referring to, since prior to 1968 transplant kidneys were taken either from related living donors or from individuals whose death was declared according to the traditional cardiopulmonary standard (could the latter be the obsolete criteria from the Committee’s viewpoint?) which at the time was the only accepted criterion of death. Thus, it seems that the only possible controversy which the Harvard

\textit{invention of Death} (Berkeley: University of California Press, 2002), 103.
\footnote{105}Pius XII, “Address to an International Congress of Anesthesiologists (24 November 1957),” \textit{L’Osservatore Romano}, November 25-26 1957.
\footnote{106}Ad Hoc Committee of the Harvard Medical School, “A Definition of Irreversible Coma,” 337.
Report alluded to would be if organs were harvested prior to true death, since such an intervention would amount to killing the patient by vivisection and, therefore, violates the Dead Donor Rule. The tacit, unwritten Dead Donor Rule stipulates that vital organs can only be taken from dead people and that “organ retrieval itself cannot cause death.” The only way to circumvent the Dead Donor Rule is to have a new criterion for determining death such that procurement of vital organs does not leave physicians open to the charge of murder. In brief, no controversy existed that needed to be resolved by the introduction of the ‘brain-death’ paradigm. Rather, by introducing it, the Harvard Committee created a controversy which has been unrelenting ever since.

The above brief analysis shows that neither of the two justifications can account for the alleged necessity to make le coma dépassé the new definition of death. Indeed, the true, first and foremost justification cannot be immediately found in the Harvard Report itself, but rather in the draft documents of the report and the correspondence between the members of the Committee during the drafting of the report.

3.2.2 The Harvard Committee’s True Justification for Identifying Irreversible Coma (‘Brain Death’) with Death

The Harvard Committee manifested its true reason for redefining irreversible coma as a new criterion of death not

only in the drafts of the Harvard report but also in the way the Committee carried out its work. In addition, it is interesting to note the biased composition of the Committee: at least six of the ten physicians (specializing in neurology, neurosurgery, renal transplantation, and anesthesiology) were brain death proponents, while there were none to represent the position of the traditional cardiopulmonary death criteria.\textsuperscript{108} That the Committee “was not a deliberative body” was recognized by its own theologian-member Ralph Porter.\textsuperscript{109} How the Committee carried out its work was also revealing: it worked behind closed doors and in a great hurry from March through June 1968. As pointed out by Giacomini, who analyzed the “Committee’s drafts, memos, and work in progress,”\textsuperscript{110}

> “The Committee’s hurried work behind closed doors expropriated the question from a host of outside parties who might not keep the interests of transplantation close at heart, among them the news media, the courts. [...] A timely statement would ward off legal challenges to transplantation, and Harvard’s successful production of the “first” statement would preempt any competing groups’ claims to authority in

\textsuperscript{108}Teresi, \textit{The Undead: Organ Harvesting, the Ice-Water Test, Beating-Heart Cadavers—How Medicine Is Blurring the Line between Life and Death}, 132.

\textsuperscript{109}Quoted in Wijdicks, “The Neurologist and Harvard Criteria for Brain Death,” 975.

\textsuperscript{110}The Committee’s drafts, memos, and work in progress are all part of the ‘Beecher manuscripts’ preserved at the Francis Countway Library of Medicine at Harvard (see footnote 95 above).
the area. [...] The urgency clearly was not on account of the clinical problem of the “hopelessly unconscious patient,” who by 1968 had existed uneventfully in hospitals for years [italics in original]:

111

The language in the drafts of the Harvard report and the memos between the Committee members constitute the clearest and most important evidence showing that the need for fresh and viable organs is the very cause to bring about the birth of ‘brain death.’ This evidence, accessible only to a few selected scholars and not to the public, reveals the centrality of organ transplantation as the true impetus for the Committee’s work. For instance, in one of his correspondences to Beecher in late 1967 regarding organs, Murray wrote:

“The next question posed by your manuscript, namely, ‘Can society afford to lose organs that are now being buried?’ is the most important one of all. Patients are stacked up in every hospital in Boston and all over the world waiting for suitable donor kidneys. At the same time patients are being brought in dead to emergency wards and potentially useful kidneys are being discarded.”

112

Likewise, the necessity of ‘brain death’ for the advance-
ment of organ transplantation was explicitly expressed in
several of the manuscript drafts, of which some of the key
passages are quoted by Giacomini. For instance, in the
conclusion of the first draft of April 11, 1968, we read the
following:

“The question before this committee cannot be
simply to define brain death. This would not
advance the cause of organ transplantation since
it would not cope with the essential issue of
when the surgical team is authorized – legally,
morally, and medically – in removing a vital
organ.’

In other words, the ‘brain death’ paradigm had to be
carefully constructed in such a way that it would serve a
two-fold purpose. As pointed out by Pernick, one of the
medical historians who had access to the ‘Beecher manu-
scripts,’ the Harvard Committee and Beecher, its chair-
man, sought “not only to promote organ donation, but also
to protect the profession against transplantation’s critics,
[... namely] against the public perception that transplant
surgeons were organ-stealing killers.”

A similar pragmatic and utilitarian language is found in
the subsequent drafts. The principal causal role of organ
transplantation in the genesis of ‘brain death’ is undeniable

\[113\] Quoted in Giacomini, “A Change of Heart and a Change of Mind?
Technology and the Redefinition of Death in 1968,” 1474.
\[114\] Pernick, “Brain Death in a Cultural Context: The Reconstruction
in the following passage from the manuscript draft of June 3rd, 1968:

“With increased experience and knowledge and development in the field of transplantation, there is great need for the tissues and organs of the hopelessly comatose in order to restore to health those who are still salvageable.”

The language contained in the manuscript-drafts of the Harvard report thus clearly indicates that which dean Ebert himself recognized, namely that Beecher and the Committee “wish to redefine death in order to make viable organs more readily available.” In the final report, the language of the earlier drafts was toned down and replaced with the phrasing of the dean, who suggested that it would be better to indicate that “obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.” This statement of the dean stands as the secondary reason (stated in the opening paragraph of the Harvard report) for the Committee’s introduction of ‘brain death’ as a new criterion of death. In other words, organ transplantation, the very reason which had been all along the driving force behind the Committee’s intense endeavor, was now given a muted expression in the final report. In

that way, it was made to appear as something of minimal importance.

Nevertheless, any astute reader can see through the veil of the revised and guarded language in the final report that the real justification for identifying irreversible coma with death is none other than the interests of the transplantation enterprise. Put bluntly, the introduction of ‘brain death’ allow surgeons to remove organs from patients with irreversible coma without risking to be accused of homicide or euthanasia. Even Peter Singer, whose utilitarian philosophical outlook is well known, affirms that “the brain death criterion of death is nothing other than a convenient fiction.” This view is corroborated by many other scholars.

In summary, the historical evidence, both external (see section 3.1) and internal, proves the close intrinsic link between organ transplantation and the genesis of ‘brain death.’ This was further corroborated by Beecher’s own

---

statement that, it is not only a waste of resources to keep the hopelessly unconscious patient on the ventilator, but society cannot “continue to condone the discard of [their] tissues and organs […] when they could be used to restore the otherwise hopelessly ill but still salvageable individual.”

For Beecher, “at whatever level we choose to call death, it is an arbitrary decision. […] It is best to choose a level where, although the brain is dead, usefulness of other organs is still present.” Beecher’s position thus fit squarely with secular utilitarianism.

3.3 Does Changing the Definition of Death Change the Reality of the Phenomenon of Death?

The above historical account of the genesis of ‘brain death’ shows that the hurried endeavor of the Harvard Committee came down to a clever exercise of deception and manipulation of the term ‘death.’ It is not unreasonable to think that the Committee knew that the public at large has always understood death in the ordinary common sense of the term whereby the phenomenon of death in a human person, biologically speaking, is no different from the death of a pet cat or dog. To achieve its purpose, however, the

---


Committee chose to use the same term ‘death’ to designate a totally different phenomenon, as if the phenomenon of death and that of irreversible coma could be conflated together.

Medicine belongs to the field of empirical sciences in which the operative cornerstone principle is scientific realism. As Nguyen points out,

“Realism demands that our concepts (along with the language we use to formulate those concepts) correspond as closely as possible to the reality outside our mind. Therefore, if a scientific thesis is not supported by empirical evidence, then it must abandoned, or if possible, substantially revised to reflect reality.”

Applying the principle of scientific realism to the controversy of ‘brain death’ means that we must, first and foremost, acknowledge that life and death are natural biological phenomena, and as such, they are mind-independent phenomena which are not “open to revision or stipulation.” The task of medical science is “to discover, describe, and explain the features or properties of each phenomenon” and, in the process, distinguish one from the other. Both life and death are universal phenomena, and within a genus of species – namely the genus of warm blooded mammals – the signs of life (and conversely the

---

signs of death) are the same across species. Over millennia man has discovered the constellation of signs which characterizes the phenomenon of death, and which is encapsulated in the medical term ‘the traditional cardiopulmonary criterion of death.’ It should be noted, however, that this term does not refer just to the cessation of heartbeat and respiration, since the definition of death prior to the 1968 introduction of ‘brain death’ does not rest on the function of any one organ, but instead “emphasize[s] the total stoppage of all vital bodily functions.”

Language, on the other hand, is a product of the human mind and social convention. As such, language can evolve and change; nevertheless such a change cannot be arbitrary but must conform to the above-mentioned principle of realism. In other words, arbitrarily “changing the meanings of terms does not change the world to which those terms refer.”

In this regard, precisely because death is a biological, mind-independent phenomenon,

“Changing the meaning or definition of death (word or concept) – that is, changing the criterion for determining death to make it correspond to something else – does not and cannot alter the nature of biological death (phenomenon). Conflating words or concepts with external reality as if the latter could be manip-

---


ulated by manipulating the former, can only result in epistemic confusion.\footnote{Nguyen, The New Definitions of Death for Organ Donation, 261.}

Thus, changing or stretching the definition of the term ‘death’ such that it also encompasses the phenomenon of irreversible coma, and changing the meaning of the term ‘irreversible coma’ such that it becomes a new criterion of death, come down to merely a manipulation of language and concepts – a manipulation which does violence to the principle of realism because those two phenomena remain unchanged, as they differ from one another as day and night. A side-by-side comparison made by Truog and Robinson between: (i) living patients, (ii) brain-dead patients and, (iii) the cadavers of patients whose death is determined according to the traditional criterion, shows the following: brain-dead patients share many features of the living – such as heart-beating, perfusion, functioning vital organs, capacity of reproducing – none of which is manifested in the group of cadavers.\footnote{See Robert Truog and Walter Robinson, “Role of Brain Death and the Dead-Donor Rule in the Ethics of Organ Transplantation,” Critical Care Medicine 31, no. 9 (2003): 2391-2396, 2392 (table 1).} The only feature which the brain-dead group shares with the group of traditional-death cadavers is the absence of the capacity for consciousness.

Put bluntly, redefining irreversible coma (the term) as death, and labelling it as ‘brain death’ does not change the reality of irreversible coma (the phenomenon), for indeed one can only be in a state of coma if one is still alive. What the severely brain-injured, deeply comatose patient
needs and deserves is to be promptly given the state-of-the-art modalities of brain-targeted therapy necessary for the acute management of severe brain injury. ¹³⁰ Instead, more often than not, such patients (especially if they are young, and constitutionally healthy before the severe brain injury), are declared brain-dead within 24-48 hours of hospital admission and quickly sent to organ-removal surgery.

4 Conclusion

In addressing the current debate on the possible opt-out legislation for organ donation in Germany, this paper has undertaken a detailed examination of both the issue of presumed consent (the basis for the opt-out legislation) and the problem of 'brain death' together, primarily because the latter is a major source of supply of organ transplants. As demonstrated in the paper, the common thread between 'brain death' and an “opt-out policy” is the ethics of utilitarianism. Another no less important common characteristic between the two is the lack of transparency. With regard to ‘brain death,’ the notable lack of transparency has been present since its inception, i.e., during the preparatory phase of the Harvard report.

Since the introduction of the Harvard Report, “government and professional organizations and advocacy groups have mischaracterized organ donation as donation after death to make it palatable to the general public.”¹³¹

¹³⁰ See Nguyen, “Brain Death and True Patient Care,” 270-272.
¹³¹ Joseph L. Verheijde et al., “Legislation of Presumed Consent for End-of-Life Organ Donation in the United Kingdom (UK): Under-
mally, after a patient is declared dead in the intensive care unit, the customary procedure includes “turning off the machines, removing the various lines and tubes, and sending the [dead body] to the appropriate place in the hospital – the morgue.” In contrast, when a potential donor is declared dead according to the ‘brain death’ criterion,

“Monitoring and intervention continue at maximal levels in order to protect and preserve organs. Health professionals must adhere to detailed instructions defining the specific physiologic and technical indexes for optimal organ perfusion, hydration, diuresis, and avoidance of infection. Should the ‘patient’ have a cardiac arrest, even resuscitation is considered essential.”

The above passage leads to this very simple question: if ‘brain death’ is death, then “which undertaker would be willing to proceed with funeral procedures […] on individuals with the diagnosis of ‘whole brain death’ prior to the removal of their organs?”

The lack of transparency, or more precisely stated, the continuing deception of the ‘brain death’ paradigm is one

---

133Ibid.
of main reasons why it still remains a highly contentious issue, with opposition mounting from various quarters including, medicine, philosophy, social sciences, as well as in the lay press. Such lack of transparency has been further compounded by the clever use of the emotionally charged terminology “saving lives” or the “gift of life” which conveys the powerful image of life. Certainly, saving the lives of patients whose organs have failed is in itself a good act. But can one justify doing evil – removing vital organs from deeply comatose patients (in so-called irreversible coma) – in order to achieve good?

That both ‘brain death’ and the current practice of consent (especially presumed consent) in organ donation lack transparency, is not something surprising, however. Both touch the core of the interests of organ transplantation. As Tottoczko points out, for a presumed consent to be valid, it “must be based on the proof or well-founded assumption that the person had been properly informed about the consequences of his or her decision. [In other words], consent can be ‘presumed’ only when people were properly informed and also given a genuine opportunity to opt out.”

This necessarily means that people “would need to be informed of the fact that they would not be dead when organ recovery begins, that they would be killed by the process.” Put simply, organ donation in ‘brain death’ is not ‘postmortem’ organ donation, precisely because “organ donation procedures begin before death.”

---

millennia have feared to be thought dead while still alive, as illustrated in Poe’s short story *The Premature Burial*, then would people not think twice before being subjected to vivisection, let alone volunteering themselves for such a procedure? Moreover, what would happen to the multibillion dollar (or Euro) transplantation enterprise if the public were to learn the truth that the alleged organ donation after death is actually the donation of vital organs before death?