Practices Used Pre and Post-mortem to Clinically Optimise Cadaveric Organ Donation: A Theistic Case for Careful Constraint

Dr Austen Garwood-Gowers
Nottingham Law School, NTU
Practice as a whole rather than just interventions

- Not just interventions but way practice as a whole affects interests of dying and dead
- Pre-mortem practices in contexts of suspected loss of brain function as well as loss of circulation
Brain stops functioning

- Desire to keep open possibility of transplant leads to attempts to maintain physiological stability so as to be able to perform tests that will (normally) confirm person is dead.
  - e.g. administration of fluids and inotropes, insertion of central venous and arterial catheters, and adjustments to mechanical intervention.
  - In sum range of interventions, some very intrusive, which generally provide no clinical benefit to those subject to them.
- clinical environment of dying person may also be impacted.

(Garwood-Gowers, 2013 drawing to some extent on Coggon and Murphy)
Loss of circulation due to heart and lungs not functioning

- Measures taken to limit ischaemic damage to organs
- Capacity to turn this group into so-called donation after circulatory death donors is affected by three interlinked factors all of which raise ethical issues.
Firstly, how one defines death in cases of loss of circulation.

- Irreversible or permanent loss of cardio-respiratory function.
- Pressure for short wait periods to be used
- No consensus over how long the wait period should be.
Secondly, minimising time between irreversible/permanent loss of function and organ preservation and retrieval measures.

- ‘A surgical retrieval team must be immediately available in a nearby theatre before death and, by implication, before cardio respiratory support is withdrawn.’ (Coggon and Murphy)

- Interventions performed to maintain organ quality whilst awaiting retrieval team.

- Quick move to op theatre after death diagnosed – limited time with family (Coggon and Murphy)
Thirdly, on performing interventions on the person to limit warm ischaemia time.

- Range from those with limited implications such as blood testing to those that are more intrusive (administration of cooling liquids via a catheter), some having potential to affect timing of death (heparin, elective ventilation)
- After death declared, possibility of restoring the supply of oxygenated blood to retrievable organs. Concerns about this technique and its implications for credibility of death testing in cases of loss of circulation.
Concerns about such practice are grounded both on

1. The approaches to death / related testing that they rely on
2. Other specific impacts on the interests of the dying and the dead.
Approaches to death/related testing

- Death severing of connection between the soul/consciousness and its related body - former no longer controls latter.
- Medical discourse – brain central integrator of the body death can be stated to have occurred when it ceases to function.
- Not just issues of how to conceive death but of going from conception to measurement of its occurrence.
Can death be measured?

- Tests only prove inability to detect what is being tested for do not prove that it does not exist.
- Past experience with death testing and PVS testing illustrates the problem.
Brain based measurements

- Took off after Ad Hoc Committee Report which ironically as Truog and Miller point out has a title which implies doubts about whether brain death = death
- Even if death = brain death a significant minority in the discourse continue to argue that even whole brain death does not in fact assure such loss
- Shah many examples of patients who are correctly diagnosed with ‘whole brain death’ but continue to perform a variety of integrative functions with the aid of mechanical ventilation and nursing care.
- Brain death arguably merely a ‘convenient fiction’ (Singer) enabling lungs, livers and hearts to be transplanted from those whose death is merely anticipated (Evans and Hill).
Circulatory measurement

- Permanent/irreversible loss of circulation treated as a separate form of death in US but merely as another way to evidence brain death in UK.
- Clash between what permanent and irreversible semantically mean and how they are being (mis)used.
- Possible to restart function a long time after longest time intervals used in guidance/practice (Petrie et al.).
- Calling people dead when this is speculative.
- Should this approach be eschewed as in Germany?
Conclusions on approaches to death/related testing

- Most in transplant community reflect secular and theistic support for inherent value of life and limits to alienability of body related interests - reflected in Dead Donor Rule.
- However, concerns about whether standards of death are consistent with this emphasis
- Also about the minority of the transplant community are prepared to sacrifice these values – either because they prioritise the procurement objective *per se* or because they are prepared to do so with respect to the dying
Other specific impacts on interests of the (probably) dying and the dead

Threat to protection from various arguments including

- Argument that rights can only be assigned to those capable of waiving them excludes both the dead and potentially those in a coma who are about to die
- Argument that as people do not suffer in such states they cannot be harmed.

Related definitions of harm e.g. conceived purely in terms of adverse impact on bodily functioning and/or mental state (Kagan)

Wilkinson – should also account for people’s goals, loves and friendships.

Useful but it breaks down when we do not know a person’s wishes, beliefs etc on a particular matter as is often the case with respect to post-mortem extraction of organs for transplantation and almost always the case when it comes to pre and post mortem practices designed to facilitate this.
Dignity as way forward?

- Approach based on inherent worth or dignity more inclusive.
- Graf-Vitzthum dignity
  - ‘is independent from the intellectual or physical character of the specific human entity, from any personal achievements, from success of failure of identity formation.’
  - ‘(e)ven when a human being is de facto incapable of self-determination, it remains in the human species, based on its ethic-autonomous potential, protected in a permanent, indispensable core of personality’
Not all theistic thought fits with recognition of inherent worth /dignity

- Referring to the Christian tradition Morris has noted how ‘the Word’ has tended to be associated with Western concepts of reason and intellectual capacity. Qualities theology considers to most closely reflect the image of God.
- To some extent true of all the major religions.
- Humans also have tendency to assume that potential difficulties they face in life are an indictment upon their past behaviour.
But moving more in that direction

- all religions emphasise spiritual connection and way of being neither contingent upon having particular capacities
- modern theistic tendency toward inclusion e.g. in Catholic social teaching strong identification with need to protect all human beings, rational capacities present to help with understanding the moral value of certain goods.
Legal recognition

- Increasing recognition of dignity as a legal norm generally
- Perhaps most relevant development is ECHR case of Elli Poluhas Dödsbo v. Sweden (Application no. 61564/00, 17 January 2006)
- Interference with the Article 8(1) rights of the applicants to move the buried body of their grandfather from Fagersta to Stockholm was considered justifiable under Article 8(2) on the basis that without evidence that their grandfather would prefer to be moved — he should be left in peace.
- Dignity – bodily inviolability extending beyond death – protection against medical use of the body after death where wishes not known.
Interests of the (probably) dying and the dead as they relate to practices

- Practices not involving intervention must still be evaluated e.g. for impact on next of kin coming to terms with the deterioration and death of a loved one.
- Interventions on both the living and dead must be assessed for intrusiveness and defacement of the body (living and dead).
- Those on the living must also be assessed for their potential impact on life/functioning.
Current ethico-legal stance to these practices

- Public hardly aware of these practices, their nature and potential effect on interests
- Uninformedness not corrected at “sign-up” (not proper consent)
- Issues typically first raised when they are about to die, at which point they are likely in a coma and thus unable to exercise choice.
- Decisions about practices thus end up being made paternalistically – usually on the basis of guesswork
- Need for more timely disclosure has not actively been pursued – fear that culture of informing will put people off agreeing to donate.
Critique

• DOUBLETHINK - paternalistic analysis of interests to subject people to the very practices that clinicians tend to worry might put people off signing up to donate if they were told about them

• Same old mix of unjustifiable paternalism and crass utilitarianism seen in the retention scandals.

• Paternalism should be limited to last resort (i.e. behind a systematic effort to inform and facilitate choice with respect to these practices).
Critique

Additional specific concerns about best interests approach in this context:

- Views of tend to be too influenced by the procurement objective particularly in the extent to which they allow speculative statements about what the prospective subject of such practices might have wished for (e.g. UKDEC guidance).
- Its nebulous nature and wide margin for practitioners to interpret it without incurring liability are of special concern given conflicts of allegiance.

Dr. Hootan Roozrokh - not guilty of felony dependent adult abuse. But reached civil settlement with family of Ruben Navarro after allegedly attempting to speed up his death for the purpose of organ harvesting by giving him ‘extra candy.’
What approach we actually need

- Require extraction post-mortem to be grounded on pre-mortem consent.
- Recognise that being informed as to potential pre and post-mortem practices is an element of that consent.
- Facilitate not just advance refusals with respect to such practices but also advance choices limited only by reference to such public policy/dignity imperatives.
Conclusions

- Approaches to death a concern, especially circulatory based standards
- Approach to analysis of other interests with regard to pre and post-mortem practices also reflective of lack of commitment to an ethics founded on respect for the individual.
- Stems from combination of forces of those who do not understand and/or are prepared to sacrifice respect for the individual per se and those who are prepared to sacrifice it for this class.
Conclusions

- Sacrificing for the procurement objective per se
- Attempts to justify dilution of protection of the bodily related interests sometimes founded on (idiosyncratic) conceptions of utilitarianism (e.g. Harris), distributive justice (e.g. Calabresi) and interpersonal justice (e.g. Fabre).
- Theistic thought tends to embrace accounts of purposeful living within which care and solidarity in relation to others has an important role to play
- BUT this needs to be based on voluntariness with respect to the body as distinct from the legitimate role the state has in determining the distribution and redistribution of interests with respect to over other aspects of reality (i.e. what we call property)
Conclusions

- Treating the dying and dead as less worthy of respect – a form of personism
- Social trend is toward protecting all human beings - personalism.
- Theistic dabbling with personism largely a phenomenon of the past
Conclusions

- Problem of not addressing context when addressing specifics
- Importance of critique of transplantation
- Need to consider reduction of demand rather than merely expansion of supply
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