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Organ Transplantation From The Deceased

Otto E. Guttentag, M.D.

Organ transplantation from the deceased has proven to be very successful. Yet so short is the time interval between the cessation of living and inoperative deterioration of the organs in question that some physicians plead for a redefinition of death which would lengthen this interval. They propose to replace the conventional signs, namely: cessation of heart beat and respiration, by other, earlier evidence. Everyone – certainly anyone who has ever taken care of young uremic patients – will fully understand this concern; yet is updating death the way to resolve their difficulties?

It is the aim of these remarks to discuss briefly some aspects of the problem and to make a practical recommendation that might serve the physicians while rejecting their request for a redefinition of death.

To begin let us clearly recognize that it is physicians who have initiated this request. No one questions their goodwill. Nevertheless, we must ask: to what extent are physicians entitled to make their demand? Is death strictly a medical phenomenon or a concept like inflammation or malignant growth? Is it derived from the experience of physicians alone? The answer is obvious. It is not. One will readily agree that death is a general biological concept; that is to say it is valid in but not restricted to the area of medicine. Physicians are entitled to ask for greater precision in defining death from their point of view but to contemplate a change in the definition of death, legal or otherwise, for reasons of medical intervention manifests a misunderstanding of the place of the concept of death. Indeed, this request invites intellectual dishonesty. It might even be said to invite murder.

To accuse the physicians of either would be absurd. As said before, no one questions their goodwill or the nobility of their purpose. Thus it would be just as absurd, not to explore the concept of death in its relationship to medicine as it would be to abandon indignantly the physicians in their predicament. There are at least three reasons for such exploration: 1) death is a highly complex phenomenon, 2) human beings, the biological organisms who are the objects of medical care, differ from the rest of the biological world in a very significant way, and 3) physician-patient relationship is much more complex and variable than that between veterinarians or tree surgeons and the objects of their care.

Death, as everyone will agree, denotes the irreversible end of a biological structure as a whole. It denotes, as probably everyone will agree too, a point of reference of, and not merely in, biology. It is, of course, quite true that such phrases as "I killed the engine" or "the wire is dead," are widely used. But again, one will agree that such language is metaphorical, not literal.

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The definition of death then is clear and simple when placed within the framework of ontological categories. However, it is inadequate when a concrete, empirical description is needed of when an organism is dead. For, as need hardly be emphasized, life is a temporal process in actuality and cessation of life takes time. Organisms are not either alive or dead. They also may be dying, and it is the recognition of this third state that has prompted the request of the transplanters.

It is beyond the scope of these remarks to dwell on the assertion that we are always in the state of dying, i.e., manifesting our mortality in all that we are, beginning with growing up. "Dying" is meant here to describe that state of existence in which certain organs or biological arrangements, required for sustaining the existence of the organisms as a whole, are very close to complete and irreversible cessation of functioning. Considering then what we know about the heart and respiration and their roles in maintaining an organism as a whole, it is difficult at the present time to consider the cessation of any other organ activity or biological arrangement to equal or surpass these two as indicators of the cessation of functioning of the organism as a whole. However, as we know now, cessation of heart beat and respiration are actually not the ultimate indicators. Organ transplantation would not be possible, if it were so. Indeed, if we can learn anything from organ transplantation in relation to death, it should be to postpone the pronouncement of death until the last tissue or cell or whatever we consider to be the ultimate living subunit has died. The request of the organ transplanters, therefore, appears to backfire. Have we after all reached our limits in obtaining human organs for transplantation short of betraying our convictions concerning death? The answer, I submit, is no. To substantiate it, we shall now examine the second problem mentioned above: the difference between man and the rest of the biological world.

Death, as stated above, denotes the irreversible end of a biological structure as a whole. What is meant by "biological structure as a whole"? It is a whole which we consider adequately described only as subject (not merely object), a center of spontaneity or autonomy in contrast to a structural whole that needs no such characterization, e.g., a machine. Biological whole also means that is a whole not at any moment of its existence but only in time, similar to a non-biological dynamic whole, e.g., a thunderstorm. (Since the developing and maturing of a biological whole is subject-born a biological whole transcends the merely re-active dynamism of a non-biological whole but that does not concern us in this context.) However, for the purpose of describing men as a biological whole the two above characterizations do not suffice. To be sure man is a center of spontaneity, some*one*, not merely some*thing*. Surely he is a developing being like the rest of the objects of our experience that we call living. But, as we all agree, he is not merely a center of urges and instincts. He is more. In the period of his greatest autonomy he is aware of his status. He "desires to know, he wonders why things are as they are." He is a conscious (which literally means: knowing "with" one's self), reflective, responsible being.[1]

It is at this juncture that man's nature in relation to death becomes

relevant. For man, one might say, may die as man, long before he dies as a biological being. If neurologists or other experts tell us that they have found some incontestable signs of a person having irreversibly lost consciousness, as indicated, for instance, by the absence of E.E.G. waves over a certain length of time we might well agree that such an individual as a man has indeed died.

It is this difference between being alive as a human being and being alive as a biological structure, and this polarity of not being alive as a human being and being alive as a biological structure that allows us (a) to remain intellectually honest, (b) circumvent the charge of murder, and (c) serve the organ transplanters. As mentioned previously, man as all biological structures, is a developing and dynamic being. Man's freedom at certain stages of his being is present only potentially or in limited form – as in children. It may be present at all stages of life only to a limited degree – as in the mentally retarded. It may be present in distorted form – as the severely mentally ill. The law recognizes this diversity. Children, the mentally retarded, and the severely mentally ill do not have the same rights in law as sane adults. Still the law protects these members of the human family and their freedom by the office of guardians ad litem.

It would seem that this principle of inalienable yet flexible protection of individual human rights within the area of human existence may well be extended to the zone in which human death and biological life meet. There would seem to be no objection to a sane adult declaring – if he so desires – that no extraordinary treatment be administered him when he is found irreversibly unconscious. Irreversible unconsciousness certainly permits relinquishment of extraordinary means; and thus the principle of man's dominion over his own person under these circumstances remains inviolate. Such declaration would be of great value to transplanting physicians in their desire to obtain human organs in time. Whether or not legal action or even legislation is necessary to make such declaration legally valid, whether a written declaration and deposition of such decision may be required, whether one may be entitled to elect fiduciaries ad mortem – modify and adapt the above mentioned legal term to this purpose – are minor technicalities. What matters here is our loyalty to man as a center of freedom and our obligation to respect this freedom in interhuman relations. Even after death in the eyes of the law, man does not fall to the level of dead animal but retains his status of mortalis deus as testified by his right of burial.[2,3]

It took the construction of the atom bomb to make the physicists recognize sin (to use the physicist Oppenheimer's words). May we physicians pause and consider what we intend to do in interhuman relations lest we commit even greater sins. Let us, of course, not forget the physicians's inalienable freedom to explore all paths toward the benefit of his patients; but let us also not forget every human being's inalienable freedom to resist manipulation. Thorough awareness of both is demanded of us.

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