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Chapter VII
Declaring Death, Giving Life

"Think not disdainfully of death, but look on it with favor,
for even death is one of the things that Nature wills"
-- Marcus Aurelius

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37. Brain Death in Global Perspective

On December 3rd 1967, in South Africa Christian Barnard performed the first successful heart transplant on 55 year old Louis Washkansky using the heart of a "brain dead" donor, Denise Darvall. Louis lived only 18 days before succumbing to pneumonia, but Barnard's second heart transplant patient (on January 2nd 1968), Philip Blaiberg, survived 19 months and fifteen days. Philip received the heart from 24-year-old Clive Haupt, a multiracial man who had collapsed on a Cape Town beach the day before. Barnard's longest surviving patient, Dorothy Fisher, received a transplant in 1969 and lived for an additional 24 years. Other transplants in the USA, Japan and other countries immediately followed Barnard's success.

In response to these historic events, in 1968, Harvard University formed an Ad Hoc Committee to explore criteria for brain death, with an explicit eye to the promise of organ transplantation. The process of reconsidering the definition of death culminated in the United States in 1981, when the *President's Commission Defining Death* proposed a new uniform standard for determining death that included both the traditional conception of death (that involves the irreversible loss of circulatory and respiratory functions) and the new concept of brain death. Now, after many years of reflection and debate, there is a clear international trend, indeed a near global consensus, endorsing as a matter of ethics and law the modern biomedical conception of brain death. The United States, Canada, Australia, most European nations, and Central and South American nations now include whole-brain death (that is, the irreversible loss of all brain function) as grounds for a determination of death.

There has been significantly more resistance to the concept of brain death in Asian countries, especially in Japan, Korea, and China. In 1968, right after Barnard, Dr. Juro Wada attempted Japan's first heart transplant but the patient died which ignited a firestorm of controversy over the idea of brain death. Indeed it took 31 years before the next transplant would be attempted in Japan. Of course, an initial resistance to organ transplantation is not really surprising. Organ transplantation clearly disrupts the natural process of loss and grief at the death of a loved one. The request to transplant an organ shifts the focus away from the deceased and focuses attention on saving the life of a stranger. This shift of attention is difficult in all cultures but it is especially contrary to the focus on the family that is at the core of Confucian ethics. In additional, physicians are generally reluctant to interfere with the family when it comes to end of life decision-making, and they will naturally be even more reluctant to intrude to ask for permission to donate the relative's organs. The situation in Asia is now changing, however. The following Asian countries have adopted the biomedical standard of whole-brain death: Singapore (1987/2004), Philippines (1991), India (1994), Japan (1997), and Korea (1999). The Islamic countries of Turkey (1979), Saudi Arabia (1986), and Iran (2000) have also adopted the standard of whole-brain death.[1] In addition, there is also an active and ongoing movement in China to also enact a brain death legal standard.[2]

On the other hand, the new conception of brain-death has always been controversial.[3] Despite this international and now near universal trend, the objections to the conception of human death as involving the death of the *whole brain* have always been philosophically powerful.[4] In short, as we shall see, the arguments for brain-death support higher-brain death (the irreversible loss of the capacity for conscious awareness), and not whole-brain death; and the objection to higher-brain death support a return to the traditional conception of death. Indeed, it is plausible to maintain that the global switch

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[1] Alireza Bagheri, "Organ Transplantation Laws in Asian Countries: A Comparative Study," *Transplant Proceedings*, December 2005; also presented at *7th World Congress of Bioethics*, Sydney Australia; Nov. 12th 2004.

[2] I am here relying in part on a paper by Li Benfu (President, Chinese Medical Association), "Ethical Issues Implementing the Criteria of Brain Death in China," 7th World Congress of Bioethics, Sydney Australia, Nov. 12th 2004.
For Chinese Ministry of Health's draft criteria for determining brain death, see the China Peoples Daily, Aug 29, 2002: http://english.people.com.cn/200208/29/eng20020829_102271.shtm; and see the American Embassy in China, newsletter Nov. 15, 2002: http://www.usembassy-china.org.cn/sandt/estnews111502.htm.
For the first recorded brain death case in China, see the American Embassy in China, newsletter May 9, 2003: http://www.usembassy-china.org.cn/sandt/estnews050903.htm;
For changing cultural attitudes on Organ Transplantation, see the Shanghai Star 07-08, 2004: http://app1.chinadaily.com.cn/star/2004/0708/fo6-1.html

[3] See, for example, Hans Jonas, "Against The Stream: Comments on the Definition and Redefinition of Death" from *Philosophical Essays*, 1974. Also see Paolo Becchi, "Are the Dead Truly Departed When We Remove Their Organs?" and Masahiro Morioka "Commentary on Becchi," in *Eubios: Journal of Asian and International Bioethics* 15 (1), January 2005, pp. 25-29.

[4] We will focus on conceptual problems and normal intuitions in analyzing the concept tof death. In addition, however, some followers of Zen Buddhism and Shintoism in Japan believe that the mind and body are essentially integrated and thus reject the idea of brain death criteria. Some, but by no means all, Orthodox Jews, Native Americans, Muslims and fundamentalist Christians also believe that as long as a heart is beating, even if by artificial means, the person is still alive. The near universal consensus is really a national consensus where the official policy and bulk of the people accept the new standard of brain death. This does not mean that all of the people do so too.

to the standard of brain death has been motivated primarily by the need for viable organs for transplant, and not by the conceptual or philosophical strength of the new definition.

Since the real issue is organ donation and transplant, we will also survey the different legal constraints on organ donation in different countries. When it comes to policies facilitating organ donation, Singapore has really taken the lead. Japan, on the other hand has been unusually cautious. In both cases, their approaches provide insights that will help us devise the key elements of a model policy that incorporates the best aspects of these different approaches. This model policy incorporates a pluralist standard of death, which allows individuals to choose a cardio-respiratory, whole brain, or higher brain conception of death. It also includes what I call a donor-recipient priority principle that gives priority to organ donors as recipient of organ transplants. Rather than requiring an organ donor card, a model policy should be based on a principle of presumed consent for organ transplant and a principle of surrogate consent. Finally, although a principle requiring family consent is too restrictive, family consultation in these important decisions should be encouraged by physicians and public policy. After evaluating different conceptions of death and a model policy for organ donation, in the last two sections of this chapter we approach the issue again starting from the Islamic understanding of human death, brain-death, and thereby explore the justification of organ transplants from a theological perspective.

Part I – Basic Issues

38. Three Conceptions of Death

There was a time when we thought of life and death to be as clear as the distinction between black and white. The light is on or the light is off. A very dim light is still on; it may be barely on but it is still on until it is off. So too, a person may be barely alive until they are really "gone", beloved still, but "departed" nonetheless. Modern bio-medicine has shaken up this old conviction and it has made us confront more directly the grey area where the body may live on after the person is gone.[5]

This is not to deny that issues of personal identity and of the relation of mind and body, the soul and its vessel, are as old as human self-reflection. What seemed clear, however, was that to be alive was to have a beating heart and the breath of life filling one's lungs. More precisely, the **Traditional Definition of Death**, now often called the **Cardio-Respiratory Standard**, maintained that *death is a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration and pulsation.* Some cultural and religious traditions put more emphasis on the breath of life while others emphasize the flow of bodily fluids, especially the circulation of blood. But these are so closely linked biologically that it makes little practical difference whether the flow of blood or the breath of life is thought to be primary. If we stop breathing our heart stops too and if our heart fails we shall stop breathing soon enough. It turns out, however, that the two are linked in a particularly interesting and salient way. If we force the lungs to "breathe" the heart will reflexively

[5] An exception to this generalization is found in Islamic ethics and law, which considers the dying person to an intermediate stage between life and death. The dying person has altered moral status in that they can no longer convert to Islam, and when dying or lingering in a terminal state Muslims also have distinct legal rights. Manslaughter and homicide include victims that are in this intermediate state. For a fuller discussion of these issues, see Chapter VII, section 41.

pump and maintain the circulation of blood. Respiratory function causes circulation and the "vital functions consequent thereon." As a result contemporary respirators can keep the body alive even when the brain is dead. Indeed, in principle, on a respirator with obvious additional interventions, a decapitated body could continue cardio-respiratory function. In such a state, whatever we say of the continued biological functioning of the body, the person is clearly gone and dead. Indeed, most people find the very idea of keeping alive a decapitated body an inhuman affront, sacrilegious, an indignity. This macabre concept does, however, typically lend some intuitive support for the otherwise unintuitive concept that, despite the pulsating and breathing body, when the brain dies the person is dead.

But why should we care about this theoretical and conceptual distinction? If it were not for organ transplantation, our interest in these modern biological possibilities would probably be confined to the philosophy departments – surely adding new fuel to disputes about the metaphysics of personal identity, but of little interest to physicians and the writers of laws. Organ transplantation, however, has led to lively debates over refining our concept of death. The philosophical debate in the West was formally started in 1968 with the Ad Hoc Harvard Committee studying the concept of Death,[6] and has also focused on the US President's Commission report "Defining Death" in 1981.[7] In the East Asia, the focus from the start was instead on above mentioned controversy over whether Dr. Wada's transplant was really a case of illegal experimentation on human subjects.[8] In Japan, there was also much discussion of the case of a *brain-dead* pregnant woman whose *life* was maintained until she (?) could give birth to her baby. What are we to say about such a case? If she is dead how can she be alive and sustaining the life of her fetus? Although these particular political discussions are clearly significant, the issue and problem is clearly really driven by the dual powers of modern medicine (1) to keep the body alive when in an important sense the person is dead and (2) to save the life of a vibrant living person when the body (or at least part of it) is dying.

The organ donor from her death gives the gift of life. This is really an amazing and wonderful thing: A living body with a brain that has died gives new life to a person with a dying body. The promise and value of life, the compassion of giving one's own body to save life, these are values and virtues embraced by all traditions; all religions; and most people. Yet our understanding of what is death, of what it is that we value when we value life, and of how we respect the dead, are also implicated by redefining death (and by the transplantation of the dead person's organs to save another's life). This is heady stuff. Individual people, religious traditions, and societies may come to different conclusions about what is right with respect to these issues, but the underlying values and the competing principles at issue are actually quite clear. It is the goal of this chapter to clarify these issues, so that we can make difficult decisions with the clearest possible sense of the issues that are at stake.

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[6] Harvard Medical School, "A Definition of Irreversible Coma" (Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death), in the *Journal of the American Medical Association* (JAMA) 205, 1968, pp. 337-340.

[7] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "Defining Death: Medical, Legal, and Ethical Issues in the Definition of Death." US Government Printing Office, Washington DC, 1981

[8] For the history of the debate in Japan see Mashario Morioka "Reconsidering Brain Death: A Lesson from Japan, Fifteen Years Experience," *Hastings Center Report* 31 (4), 2001, pp. 41-46.

Although there is indeed an international consensus in support of the Whole Brain Standard, it is actually unclear why this conception is preferable to either the Traditional Cardio-Pulmonary Standard,[9] or alternatively, to a Higher Brain Standard of death,[10] which focuses on the biological basis of the capacity for consciousness. The simple idea supporting a Higher Brain Standard is that once we are motivated to switch to a brain-based conception, which focuses on the death of the person, it is the irreversible loss of the capacity for consciousness itself that should be the focus of the concept of death; and not the death of the whole brain which includes even the brain stem. As so many Asian countries switch from a cardio-pulmonary to a brain death standard, and in the midst of China's discussion of a brain-death law, it is worth pausing and reflecting on the important objections to this recent trend.

The process of reconsidering the definition of death culminated in the USA in 1981, when the President's Commission Defining Death in the United States proposed the following **Uniform Determination of Death Act:** *An individual who has sustained either (1) irreversible loss of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.*

The Uniform Determination of Death Act conjoins a conception of irreversible loss of brain function with the traditional cardio-pulmonary standard. By including the traditional standard, it allows the determination of death to continue to occur in the vast majority of cases in accordance with current medical standards, and yet by incorporating brain-death too, it recognizes that a person whose brain is dead and whose body is sustained exclusively by external artificial means has indeed died. On this definition, brain death is sufficient for death, even when circulation and respiration continue by artificial means. Since brain death always results from the irreversible loss of circulation and respiration, brain death is the primary standard of death under this new uniform definition. Yet under this dual standard for the determination of death, the criteria and the (sophisticated and expensive) medical tests to establish brain death are unnecessary for the *determination* of death in the vast majority of cases. The underlying *standard* of death, however, is death of the brain. The death of the person involves the irreversible cessation of all functions of the entire brain.

The Whole-Brain Standard *requires the irreversible loss of all function of the entire brain: the cerebrum and cortex, the cerebellum, and the brain stem composed of the midbrain, pons, and medulla oblongata.* Why then should we redefine death in this way?

There are two main reasons typically given in support of the standard of whole-brain death. First, the brain is the locus of death, it is argued, because it is the "primary organ" of distinctive human life, of our personhood, and our distinctive humanity. We will turn to this idea in a moment, but for now it should be clear that what is distinctive and special about human life (whatever it is one takes this to be) can be irreversibly lost

[9] For an interesting critique of the use of the concept of brain death for organ transplantation, and an interesting argument that we should return to the traditional definition of death but abandon the "dead donor rule" for organ transplantation, see Robert D. Truog "Is it Time to Abandon Brain Death," *Hastings Center Report* 27 (1), 1997, pp. 29-37.

[10] For a critique of the Whole-Brain standard and the arguments for a higher-brain standard, from which I have learned much, see Robert M. Veatch, "The Impending Collapse of the Whole-Brain Definition of Death," *Hastings Center Report* 23 (4), pp. 18-24.

prior to the death of the entire brain. If only the brain stem lives on, and all else is lost, the person is just as clearly dead in this case as the case of whole brain death. So why require the irreversible cessation of functioning of the entire brain? It is the "higher-brain" that sustains consciousness and thus all that is distinctive of our humanity. The higher-brain standard is an alternative to the whole-brain standard and it will be discussed more fully below.

The second rationale for a standard of whole-brain death focuses on the biologically distinctive role of the human brain in maintaining and sustaining human life. The brain is essential to the integrated functioning of the body's other major organ systems. The brain, including the lower brain and brain stem, is the command center of the body. Indeed, bodies with only lower brain-function can breathe, metabolize, maintain temperature and blood pressure, and also sigh, yawn, track light, and react to pain or reflex stimulation. It is thus argued that a person with continued lower brain function is thus clearly still a living, human life. It is counterintuitive indeed to declare such a living body to be dead.

It has been argued that this second argument actually supports a *Brain-Stem Standard* of death, since it is the brainstem that is responsible for the integrated biological functioning of a human being. The irreversible loss of brainstem function is biologically linked to the irreversible loss of the capacity for consciousness and of independent cardio-respiratory function, it is argued, and so it marks the death of an independently functioning human being. The standard of brainstem death received significant attention in the United Kingdom in the late 1970s, and it was adopted as the standard of death in India in 1994.[11] Nonetheless, whatever its distinctive merits, since the concept of whole brain death includes brainstem death, we shall focus primarily on the more common, indeed near universal, whole-brain standard.

There are, however, complexities and problems that are too often ignored by those defending the whole-brain standard of death. First, in practice "whole" brain death actually involves loss of all *significant* functions, and not "all functions," because cellular level functions, nests of cells and super cellular-level functions remain long after the "brain" has irreversibly stopped functioning. The same, of course, is true of any part of the human body. There is insignificant biological and cellular functioning that continues long after the irreversible cessation of cardio-pulmonary function. Whatever the definition of death, we must acknowledge that the organs and cellular activity of the body dies off slowly after the person has died. When significant function is lost, the person is dead, despite the human biological "life" that continues during the slow process of cellular death, necrosis, and decay. In the case of brain death, when measuring to see if there is continued neural activity, small (2 microvolt) electrical potentials on an EEG are thus discounted by "whole-brain" determinations of death. A flat EEG is easily achieved by the choice of the sensitivity setting on the EEG machine.

It is worth noting once again that these considerations are also used as a rationale for focusing on the brainstem in particular, rather than the whole brain. It is the loss of the integrated biological functioning of the brainstem and not other isolated functions that is significant, it is argued by defenders of the brainstem standard. If this is the case, the

[11] For a defense of the brainstem standard, see Chris Pallis, "On the Brainstem Criterion of Death," in *The Definition of Death: Contemporary Controversies*, ed. Youngner et al., (Johns Hopkins University Press, 1999), pp. 117-36.

whole-brain and brainstem conceptions are equivalent in that the "significant" functions emphasized by the whole-brain defenders are instantiated by the brainstem. Nonetheless, the whole-brain conception has the advantage of clearly including higher brain cognitive functions and the capacity for consciousness in its conception of what must be lost for death. If it were possible, as is clearly imaginable, to artificially replace all brainstem functions, so that the brain stem could "die" in a conscious and even lucid person, such a person would clearly still be alive. (Of course, if biological brainstem function is in fact necessary for consciousness, then this is not an empirical possibility.) The whole-brain standard makes explicit that death of a person requires cognitive death.

On the other hand, this raises the question: why not focus on what is truly the "significant" function of the "whole" brain, that is, the cognitive capacity for conscious awareness? Indeed, advocates of a Higher-Brain Standard, in criticizing the whole-brain standard, emphasize that the continued functional activity that occurs when only the brainstem still functions is essentially reflex activity that is on a par with reflexive spinal cord activity. Like the supercellular functions that remain after a declaration of "whole" brain death, this activity also simply is not "significant" functioning. This activity includes breathing, metabolizing, maintaining bodily temperature and blood pressure, and the body may also sigh, yawn, track light, and react to stimulation. Although it is natural to have an emotional response to a subject displaying this type of reflexive functional activity, these continued functions simply do not indicate any conscious awareness or any significant cognitive functioning. Of course, a brain-dead body on life support also reflexively continues functioning. Whole-Brain advocates argue, however, that, since these are simply spinal cord reflexes, they do not indicate continued functioning of the brain. This, however, simply highlights the problem: If *spinal cord reflexes* can be ignored, as is maintained by whole-brain accounts, why not the *brain stem reflexes* as well? Indeed, the spinal cord is a continuation of the brain stem and so there really is no significant difference between the one and the other. When higher brain function is irreversibly lost, the being that remains is in limbo between life and death. Complex biological functions remain but all possibility for even the most minimal conscious awareness is forever lost.

The reason the uniform standard of death gives primacy to the brain is that its death marks the death of an individual with consciousness. The definition of death is important, of course, because we are concerned with protecting each individual person from premature declarations of death. It is the individual person who is the subject of our moral concern, and therefore the focus should be on the death of a person. To be a person, and not a mere thing, involves many cognitive and higher order mental capacities, but the most basic and essential capacity is that a person has the capacity for conscious awareness.

These considerations, when combined with the above objections to the whole brain standard, suggest that we should adopt a "higher-brain" standard of death. According to **The Higher-Brain Standard**, *the person dies when there is an irreversible cessation of the capacity for any form of consciousness, and consciousness is forever lost with the irreversible cessation of cerebral, higher-brain, functions.* If we are moved to modify the traditional cardio-pulmonary concept of death, it is the continued capacity for conscious life that should be our focus of concern. Although it has received little support

from medical associations and public officials, the higher-brain standard is the philosophically favored standard of brain death.

So why is it neglected in favor of the philosophically weaker whole-brain standard? Some critics raise concerns over the criteria for measuring higher-brain death. The irreversible cessation of all brain activity can be measured and determined with reasonable certainty, but *irreversible* loss of consciousness is notoriously much harder to determine. Defenders of the higher-brain standard respond that first, there is sufficient accuracy in measuring persistent loss of all consciousness, and, second, that this is a clinical issue but not a challenge to the definition itself. The latter point is indeed important. We need to clearly distinguish what we are trying to determine, the death of the person, and the criteria we use to make this determination. In the case of the traditional definition of death, there have been many cases of mistaken declarations of death. But this does not undermine our confidence in the traditional standard of death itself. What we should conclude instead is that a level of conservativism is called for when making a determination of higher-brain death. Although on this *standard* we are indeed dead when the capacity for consciousness is forever lost, the *criteria* determining death could be based on the irreversible cessation of all significant neural activity of the cerebrum, cortex, and the cerebellum; essentially all brain activity other than mere brain stem activity.

A related concern takes the form of a classic "slippery slope" argument: If consciousness is what matters for life, does this not also (unacceptably) imply that those with severe dementia, and thus marginal or significantly diminished consciousness, have also lost their personhood? If we are interested in the death of the person, why aren't they dead? This is an important objection. In response, we must draw a distinction between the irreversible loss of the particular person, as a subject with a continuous personality, from the death of the person. To take one all too common example, although in one sense we do lose our loved one, when they are suffering from advanced dementia, they are still clearly a conscious living person. These types of cases show that it is a mistake to focus on loss of personality in the definition of human death, but they do not present a challenge to consciousness based conceptions of death. Quite simply diminished consciousness is still consciousness, and so, on the higher-brain standard, whenever there remains the possibility of any form of consciousness, the person is not yet dead. Without embracing dualism, we can all see a clear sense in which human life involves in an important sense the union of a conscious mind and a living body.

Nonetheless, however strong these philosophical arguments may be, the higher brain standard is very counter-intuitive. Although it is a stretch, and somewhat of a contradiction, to think of a brain dead body on "life support" as already dead, it is even harder to think of a body whose higher-brain is dead but yet that is still naturally (reflexively) breathing as dead. This is the problem of the still breathing but dead patient. Some respond to this problem by arguing that we need to now distinguish the death of the person from the death of the biological organism. The person dies when the possibility of consciousness is forever lost. The living body that remains when all consciousness is forever lost is the person's "living remains." In many ways this language already captures how many people do think in these types of unusual and difficult cases. When a brain-dead patient on life-support dies, we realize that it is for the best because our loved one was already gone. If a society ever moves to a higher-brain

standard, it may also come to seem natural to distinguish the death of the person from the death of the rest of their body, but for now the mere fact that the persons body is only artificially sustained and that it dies too when life-support is removed keeps us from having to conceptualize the life that remains when a person is brain-dead. But does the mere fact that life is artificially sustained really make a difference to the status of a body as living or dead? Is not the body just as alive when life is artificially sustained?

To be clear, this is not to deny the permissibility and indeed reasonableness of turning off all life support whenever brain-death, either whole-brain or higher-brain, has occurred, and letting the remaining body die. When a person has forever lost the capacity for consciousness, it is hard to see how (barring fantastical assumptions) we can benefit them in any way by keeping them alive. We here have an unusually clear case of medical futility. In the case of higher-brain death, the withdrawal of all life support, including intravenous nutrition and hydration, may be appropriate and reasonable (perhaps depending on the values and principles of the patient). It may even be the case that, in cases of clear higher-brain death, more active means of causing bodily death are appropriate. The point is simply that we should not confuse the decision that it is reasonable to let a patient die with the quite different judgment that a patient has already died.

To summarize:

- **The Traditional Cardio-Respiratory Standard** of death has the intuitive advantage of identifying life with the vital functions of pulsation and breathing that are the clear indicators of and a necessary condition of life. Indeed intuitively the lack of pulsation and respiration may also be a necessary condition of death. The problem is that these conditions do not seem to be sufficient for life when the whole brain (or the higher brain) is dead.
- **The Whole Brain Standard** has the clear advantage of identifying death with what seems to be the body's commanding vital organ and the seat of consciousness. The problem with the traditional standard is that the life of *the body* can survive beyond the point where it can sustain the life of *human being* as a possible subject of consciousness. A living body with no brain function is not the human life that is the subject of our moral concern. So the continued possibility of a functioning brain is a necessary condition for continued life. The problem is that, first, the higher-brain, not the whole-brain, is the necessary basis of continued consciousness. A body with only a living brain stem is biologically incapable of sustaining consciousness. We care about the brain because without it the person is forever gone, but the person is forever gone when all but the brain stem remains. The second problem is that the whole-brain standard arbitrarily draws a distinction between brain stem activity and spinal cord activity that survives the death of the brain stem, yet there is no relevant difference between these activities. From a biological and functional point of view it is arbitrary to draw a line through the spinal cord at the base of the brain. This is a conceptual distinction with no significant biological basis.
- **The Higher Brain Standard** has the clear advantage of identifying death directly with the capacity for continued conscious life. A human body with only brain stem function is truly an automaton completely incapable of any form of conscious life. The brain must be able to sustain conscious human life if it is

described as still having significant function. Just as super-cellular higher-brain activity and spinal cord reflexes are not "significant" function for whole brain advocates, so too, and for the same reasons, brain stem activity alone is not significant brain function for the purposes of declaring the death of a person. The problem with this seemingly philosophically sound distinction is that it is overwhelmingly counter-intuitive to declare dead an independently breathing, pulsating, and functioning human body. (Although we (societies) may someday accept the idea of a person's "living remains," common sense thinking, and thus public policy, is still far from that day.) This suggests, however, that from the common sense point of view an independently breathing body is sufficient for life. But what is the vital difference between a body living with the support of a respirator and one off life support? A conscious person is no less alive simply because they are dependent on life support. Both are equally alive – that's why it's called "life" support. Since it is hard to see why it should matter if cardio-respiratory activity is naturally or artificially sustained, some argue that only the traditional definition of death in fact captures our intuitive common sense distinction between life and death. This suggestion, however, brings us full circle and back to the problems with the traditional standard of death.

Thus we see that the distinction between Life and Death is just not as clear-cut as we assume, and would like, it to be. The truth is that there is the death of the person, the death of a conscious life, the death of all but the brain stem, the death of the whole brain including the brain stem, the death of cardio-respiratory function, and the death of the persons' viable organs and ultimately of all cellular life. Declaring death is always contextual and specific. Furthermore, these competing standards of death also reflect different evaluative principles and distinct spiritual beliefs about the nature and essence of human life.

39. Minimally Conscious States and Persistent Vegetative States

There is one more issue that further complicates these issues. It has become increasingly clear that in addition to the distinction between consciousness and persistent vegetative states (PVS), we also need to distinguish these states from a coma and from minimally conscious state. The confusion between these different states is a source of much unnecessary controversy. First, a **Coma** is an unconscious, sleeplike state that is subject to a range of unresponsiveness to pain and sound. These range from a scale of 3 for "no response" to 13 for "consistent response." Coma states tend to last for only two or three weeks at which time subjects *seem* to emerge when their eyes spontaneously open and sleep-wake cycles begin again. The lucky then gradually truly wake-up and return to full awareness. In some cases of significant higher brain injury, the cerebral cortex does not "reengage" and the person irreversibly loses all conscious awareness – despite the sleep-wake cycles and other spontaneous reflex response behavioral activity. These patients are properly designated as in a persistent vegetative state (or PVS). The PVS patient has sleep wake-cycles, some reflex responsiveness and can breathe, metabolize, maintain temperature and blood pressure, and also sigh, yawn, and in some cases can track light, but has no capacity for conscious awareness.

The first months after "waking" from the coma are a crucial indicator of the future prognosis. If conscious awareness does not return within a year, then the likelihood of

recovery of consciousness is dim. In some cases, however, the patient seems like a PVS patient, but has intermittent partial awareness. Imaging technology reveals that these patients have significant cortical activity in response to stimulation that is lacking in PVS patients. This class of patients is now referred to as being in a **Minimally Conscious State (MCS).** Patients in minimally conscious states almost always regain consciousness within a month of initially emerging from a coma -- but MCS can last for years or even a lifetime. This accounts for stories of people recovering from "comas" (or from "PVS") after 18 or 19 years. These patients actually showed signs of minimal consciousness, despite their general unresponsiveness.

So how can we tell the difference between PVS and MCS? First, minimally conscious states seem to correlate closely with blunt traumatic brain injury, as opposed to brain injury caused by oxygen-deprivation. The reason for this is that oxygen deprivation has an effect on the whole brain, and thus causes generalized irreversible cortical damage. Second, current imaging technology is an excellent indicator of minimally conscious states. PVS patients lack integrated cortical electrical activity that occurs with MCS. PVS patients also tend to have substantial brain atrophy and degeneration of the cerebral cortex which eliminates the possibility of the recovery of consciousness.

Nonetheless, the reactive behavior, sleep wake cycles, and apparent intentionality, of a PVS patient are clearly confusing to family members and loved ones. In addition, the stories of some (MCS) patients recovering after 18 years, and the previously poorly understood nature of MCS also fuels the hopes of those caring for PVS patients. Although there are borderline cases that are difficult to diagnosis, there are also cases that approach medical certainty. The problem remains, however, that for some patients it will be unclear whether they are in a minimally conscious state or truly in a persistent vegetative state. [12] The difficulty of distinguishing MCS and the higher-brain death of PVS provides a practical reason in support of a whole-brain conception of brain death. Although there are clear cases of PVS, there are also borderline cases where patients may still have minimal consciousness and the possibility of recovery. On the other hand, even if the specific criteria of whole-brain death are also somewhat indeterminate, there is no possibility of consciousness in cases of whole-brain death. As a pragmatic matter, it thus may make sense to have the default standard of death be whole-brain death, and to adopt a policy of allowing patients to die when it is reasonable to believe that the patient is PVS and has irreversibly lost the capacity for consciousness.

40. Giving Life – Organ Transplantation

Things would be simpler if it were only the determination of death that was at stake, but the promise of giving life through organ donations has always added an urgency and direction to these debates. As the result of basic biology, living organs need

[12] In the case of Terri Schiavo, which was a significant political issue in the United States, her medical prognosis was very clear:

- she suffered from significant oxygen deprivation,
- she had not suffered a traumatic brain injury,
- she had no cortical EEG activity,
- her brain had atrophied, and her cerebral cortex and visual centers had completely degenerated. –

Thus evidence of PVS was "clear and convincing" and indeed it was even "beyond a reasonable doubt." Her "higher-brain" that is the seat of consciousness had indeed completely died long ago.

continued cardio-respiratory activity. We thus maximize the success of organ transplantation by harvesting the living organs when the brain dead body is still on life-support. In many cases, this leads to the practice of establishing first that the accepted medical criteria of whole-brain death have been met, second, turning off life-support, so that traditional cardio-pulmonary death occurs, and declaring death, and, third, resuming life-support to maintain the organs for the transplantation operation. In this roundabout way, what has been called, the "dead donor rule" for organ donation is supposedly satisfied.

Some have suggested, Truog most explicitly,[13] that it would be preferable to return to the traditional cardio-respiratory standard of death, but abandon the dead donor rule for organ transplantation, or more accurately that we should just specify that a determination of brain-death is sufficient for organ transplantation. Defenders of the traditional definition have always focused on the continued moral standing of the living human biological organism. In support of this, they point out the near universal rejection of the use of brain dead bodies for blood banks or organ farms. Indeed we would never bury or cremate a brain-dead but still breathing body, they argue. The total unacceptability of these ideas, they argue, reflects our clear sense that the person, and not just a body, is still alive.

The rejection of such macabre ideas, however, may simply reflect our normal sense that we should respect a person's body, in this case the "living remains," even after death. In all cultures there are rituals and rules about how one respects the dead. The near universal aversion to turning a dead person's body into a blood bank may simply reflect the incompatibility of this idea with cultural rituals and rules, and need not reflect a clear judgment that the person is still alive. Indeed, a major conclusion that we can draw from these issues is that our "clear" traditional intuitions about death are simply *not prepared and attuned* to deal with the moral complexities of truly novel medical and technological possibilities like the giving of life by transplanting the living organs of a brain-dead body, which is itself maintained and sustained by modern medical technology.

Here is a proposal: First, we should follow the Japanese example and adopt a **Pluralist Standard of Death**.[14] The law in Japan allows an individual to choose either a brain based or a traditional cardio-respiratory standard of death. We would expand this to include all three standards of death. A pluralist standard acknowledges and recognizes that there is no biological fact of the matter that distinguishes *significant* human life from death, that there are *three clear positions* that one can take on this issue, that it is a *spiritual matter* or *value judgment* that determines one's view of this question, and thus that different individuals should be allowed to choose from among the three

[13] See note 7 above.

[14] Mashario Morioka "Reconsidering Brain Deatrh: A Lesson from Japan, Fifteen Years Experience," *Hastings Center Report* 31 (4), 2001, pp. 41-46. Robert M. Veatch argued for a similar idea in the form of "conscience clauses" that allowed individuals to choose their own conception of death as early as 1976, in *Death, Dying and the Biological Revolution* (Yale University Press, 1976), pp. 72-76. For a more recent statement of his position see, Veatch "The Conscience Clause" in *The Definition of Death: Contemporary Controversies*, ed. Youngner et al., (Johns Hopkins University Press, 1999), pp. 136-60. In the United States, New Jersey (in 1991) enacted a statute with a conscience clause for religious objectors in particular to reject brain death in favor of the traditional cardio respiratory standard. The New Jersey law, however, does not allow one to opt for a higher-brain standard or to object to brain death on secular grounds. On this issue see, Robert S Olick, "Brain Death, Religious Freedom, and Public Policy," *Kennedy Institute of Ethics Journal* 1 (4), 1991, pp. 275-288.

different standards of death. The individual's choice could easily be added to living will documents and/or organ donation cards. More generally, as a matter of public policy, organ donor status and preferred definition of death can easily be indicated on driver's licenses or identity cards. As a default standard, either the traditional standard as used in Japan, or the whole-brain standard, could be used. The whole-brain standard has the advantage of being the moderate position, and the most intuitive position (in that, unlike the higher-brain standard, it does not judge a body with independent biological functioning as dead, or claim that the person is not dead when there is no brain function and no possibility of independent cardio-respiratory function, as maintained by the cardio-respiratory standard). Nonetheless, the decision on the default standard, for an individual who has not expressed a preference, is really a matter of public policy. In respecting community and individual values, it clearly makes sense to choose the standard of death most widely accepted in the society, and not surprisingly in most societies the whole-brain standard of death for organ transplantation is accepted by about 70-80% of the population. A society might, however, opt for any of the three standards of death.

A Pluralistic Standard of Death does add complexity to a legal system, and Alexander Capron argues that it thus "sows confusion and invites litigation."[15] The problem here is that a person may be declared dead under one standard but alive under another standard, and this can give rise to controversy and indeterminacy in the criminal and civil law. The obvious legal issues here include homicide, wrongful death, inheritance, life and health insurance benefits, and marital status.

Despite these initial concerns, however, it is not clear why "pluralism about death" raises any serious problems: First, inheritance law involves the personal transfer of property and so clearly fits with the individual or family's judgment about the nature of death. Second, life and health insurance is either a contractual or social entitlement and should thus be governed accordingly. Third, the issue of marital status raises its own special issues that will clearly depend on cultural norms in different societies. Fourth, in cases of the determination of homicide and wrongful death, the societies default standard is the obvious "neutral" legal standard for prosecution of crimes and adjudication of harms. Finally, although, it is likely that these particular social and legal issues can easily sort themselves out overtime, and that they need not give rise to confusion or unnecessary litigation, one obvious simpler solution is to have one standard of death, the default legal standard, serve as the State's Legal Standard for purposes of the criminal and civil law.

Alternatively, since the harm of death is clearly present in all cases in which a person suffers irreversible loss of the capacity for consciousness, the standard of higher-brain death may actually be the best legal standard of death for use in the criminal and civil law of homicide and wrongful death. It clearly seems appropriate to treat an action (or culpable omission) that causes an irreversible loss of the capacity for consciousness as equivalent to the harm of death for purposes of sanctions and civil damages. The problem here, however, is that the criteria for discerning higher brain death are more controversial and thus could lead to greater indeterminacy than either the whole brain standard or the cardio-respiratory standard. So we are left with a public policy decision

[15] Alexander M. Capron, "The Bifurcated Legal Standard for Determining Death" in *The Definition of Death: Contemporary Controversies*, ed. Youngner et al., (Johns Hopkins University Press, 1999), pp. 117-36; p.130.

of how a society decides to balance the need for determinacy in the law and the demands of retribution and rectification for serious harm. Societies can reasonably disagree on how to balance these values.

From the start in 1967, the primary social goal motivating the rethinking of the standard of death has clearly been the concern to facilitate the possibility of life-saving organ donation. By switching our focus, from the definition of death, directly to organ donation, we may more directly and effectively adopt policies that facilitate and encourage organ donation. Here we find some interesting and promising proposals that are already on the books in Asian countries and that when brought together offer a model for organ donation policies.

Donor-Recipient Priority Principle: In addition to standard policies for the allocation of organs like medical need, medical utility, and first come first serve, all countries should follow Singapore's lead and give recipient priority to declared organ donors over other persons who have not consented to be an organ donor (or where applicable who have signed an objection to donor status card). This is a simple matter of reciprocity (they who will not give shall be the last to receive), and also recognizes that conscientious objectors have no grounds for complaint when they must live (or die) by their own principles. Of course the fair implementation of such a policy will depend on the other policies in place that facilitate the identification of willing donors. Giving first priority to declared donors may serve to make individuals pause and reconsider the basis of their own refusal to offer the gift of life to others. I suspect more people will consent to organ donation when they consider the consequences of refusal. Although this may seem to be a harsh appeal to self interest, this policy simply asks that we do unto others as we would have others do unto us -- and this principle of moral refection is embraced by Confucian, Buddhist, and Christians alike. Indeed, it is also reflected in Kant's categorical imperative and in utilitarian principles of impartiality and concern for the good of all.

In addition, Singapore was the first country to adopt a **principle of presumed consent** for organ donation. Other European countries have since also adopted a principle of presumed consent, including Austria, Spain, and Belgium. In these countries, the opt-out rate has been around 2%. It has been argued that keeping track of the 2% who don't wish to be Donors would be easier than tracking the 98% who do wish to be Donors or don't care. With over a 90% donation rate there is a dramatic increase in available organs for transplant. At present it is difficult to confront a family dealing with the traumatic loss of a loved one and request permission for organ donation. Another clear benefit is that presumed consent relieves the family from this burden of decision-making about organ donation.[16]

The assumption behind presumed consent is that a reasonable person would not object to donating their organs after death so as to save the lives of others. Rather than signing an organ donor card, one signs an organ objector or refusal card. This is analogous to the model of presumed consent that is common practice in medical emergencies. We assume that a person wants to be saved unless they have a DNR order, or perhaps a living will (or medical bracelet) stating that they are a Jehovah's Witness

[16] For more information on presumed consent see http://www.presumedconsent.org/solutions.htm. For the British Medical Association position in support see http://www.bma.org.uk/ap.nsf/Content/OrganDonationPresumedConsent.

and conscientiously object to blood transfusions. The assumption is that a reasonable person would want to be saved and thus would consent if they could. Similarly, for organ donation we should assume that a reasonable person would want to help others in serious and mortal need, when they can do so at no cost or harm to themselves. If one has a religious objection, or any other objection, to saving other's lives in this way, then one has the individual responsibility of making this declaration.

Although I am sympathetic to the principle of presumed consent, its basis is less clear in the case of organ donation than emergency medicine. The assumption that one wants life-saving emergency medicine reflects a clear preference that people have for life. Obviously, people do not yet have such a clear preference supporting organ donation. So, the justification of a principle of presumed consent must be based on the assumption that a person would want to be saved by organ transplantation combined with the above moral principle of donor-recipient reciprocity. Since the assumption that people endorse organ transplantation is an empirical principle that may or may not be true, a principle of presumed consent is most clearly justified in societies that have already formed a consensus in support of organ transplants. It follows that the principle of presumed consent typically should not be part of the first step in the implementation of organ transplantation policies, and that it is rather a principle to be added once a favorable consensus has established itself.

In the absence of a recognized principle of presumed consent, a **principle of surrogate consent** is all the more important. Surrogate consent to organ donation plays an important role in countries where a common, easy, and widely used system for determining organ donor individual preference is *not* in place. If every driver's license and every identification card included donor preference, surrogate consent would be less of an issue. As it is, however, whether consent is required or presumed, surrogates are an important means of determining the values and wishes of potential donors. It is indeed common practice, indeed near universal, to permit proxy consent for organ donation. Japan is quite distinctive in that it does not accept surrogate consent and in fact requires a written donor card co-signed also by a family member. This is sometimes called the family veto principle, and, as Bagheri has pointed out, it is puzzling and perhaps inconsistent to allow a family veto and disallow family surrogate consent.[17]

In point of fact, however, the policy in Japan actually is not really a family veto, which implies any family member can veto an individual's decision, but instead it is a requirement to have one family member agree with one's decision and sign the donor card. The family co-consent is thus not as restrictive as it may at first seem. The requirement is simply to have one family member support one's decision. This family member's concurrence in the decision could have the advantage of informing and including family members, and this in turn could minimize objections at the crucial moment when the donor is brain dead and the need to transplant is at hand. Encouraging prior **family consultation** is indeed a very good idea. In the United States, a supposed bastion of individual autonomy and self determination, it is a common occurrence that the donor's expressed and explicit wishes are set aside because the family did not consent to the organ donation. For surely complex reasons, physicians routinely bow to the wishes of a living, grieving family member over those of the dead patient. We can be confident

[17] Alireza Bagheri, "Criticism of 'Brain Death' Policy in Japan," in *Kennedy Institute of Ethics Journal* 13 (4), 2003, pp. 359-372; especially p. 364.

that this would be less common if family members were included and indeed had consented in advance to the donor's decision. Without supporting a requirement for family co-consent, it clearly is advisable to include family members in one's decision making and to generally disclose one's donor status to one's family. This is best encouraged, however, in the context of a physician's office or through public information campaigns, rather than a restrictive requirement.

A final point, we need to consider the sensitive subject of **organ donation from minors**.[18] In Japan, children under 15 can not consent to be organ donors, and since Japan does not recognize surrogate consent, this is a significant obstacle to saving young children in need of a life-saving transplant. The age for donor consent varies significantly in other countries: the age for organ donation is 16 in Korea, it is 18 in India, the Philippines, Saudi Arabia, and Turkey, and it is 21 in Singapore for dissent (since they presume consent in Singapore). In these countries, however, parental and surrogate consent is recognized and so the effect of the age restriction is to leave the decision with parents or guardians. The range of ages for consent in these countries reflects the fact that it is simply not clear what the standard for competency should be for consent to organ donation. I would think that the appropriate standard is the common medical standard of informed consent, and that the typical 16 year old adolescent can sufficiently understand the issues at stake in organ donation. Alternatively, using the age standard for voting or enlisting in the military, often the age of 18 is more conservative and has the advantage of consistency in public policy on the age of consent. Whether it is 16 or 18, it would seem that even a twelve year old child can have some understanding of the issues involved in organ transplantation and brain death, and so perhaps a principle of co-consent of parents and the adolescent is to be preferred for the ages 12-16/18. The specifics of the age of consent, however, clearly reflect cultural differences that public policy should accommodate, but the principles guiding the policy choice are still clear enough: On the one hand, informed consent when appropriate and, on the other hand, the importance of respecting parental consent for children in the parent's care.

The restriction in Japan on parental consent for minors is puzzling; it is not clear why such a sweeping restriction on organ donation from minors is necessary. First, just as we trust family members to look out for the interest of their children in parental consent to medical care, here too we should defer, other things equal, to parental consent in organ donation and in the definition of death. A child's death is a terrible devastating event, and the death of two children is twice the pain and devastation. A systematic policy prohibiting child organ donation makes no sense. Although some parents may oppose, for reasons of conscience, the standard of brain death, and although some parents may choose not to donate the organs of a lost child, we should not stop the people who are willing to give the gift of life to another from finding a small solace in their loss in the effort to save of the life of another child. If the concern is simply to protect children,

[18] On the issue of child consent, see Masahiro Morioka, "Current Debate on the Ethical Issues of Brain Death" -- *Proceedings of International Congress on Ethical Issues in Brain Death and Organ Transplantation,* University of Tsukuba, (2004):57-59. For criticism of Moriorka's view, see Bagheri, "Children Competency and donor's prior declaration," *Eubios Journal of Asian and International Bioethics* 11(6) pp: 195-6 (2001). For a clear and compelling defense of the principle permitting surrogate decision making for minors and the "principle of limited familial autonomy," see Veatch "The Conscience Clause" in *The Definition of Death: Contemporary Controversies*, ed. Youngner et al., (Johns Hopkins University Press, 1999), pp. 136-60; especially pp 145-46.

some sort of judicial review may provide a middle ground. If however the restriction on child organ donations reflects a simple categorical presumption against organ donation, against the gift of life, we have seen that there is no philosophical basis for this seeming bias. This is not to say that the expressed view of minor children is to be simply dismissed. In the cases that involve adolescents between the ages of twelve and sixteen, the benefits of respecting the wishes of the individual, when they have expressed an informed preference, typically should be considered equally with those of the parents.

Elements of a Model Policy

In sum, a model policy for declaring death and facilitating the giving of life through organ donation will include the following five elements:

1. A pluralist standard of death
2. A donor-recipient priority principle
3. A principle of surrogate consent, and when appropriate a principle of presumed consent
4. A recommendation for family consultation
5. Surrogate parental consent for minors under 16 (or 18), co-consent, i.e., parental consent and prior consent honored, for ages 12-16 (or 18)

These elements both recognize reasonable disagreement on the standard of declaring death and, at the same time, they directly build a social context that facilitates the giving of life through the modern medical miracle of organ transplantation.

PART II – Islamic Perspectives

41. Islamic Ethics and Brain Death

The Islamic tradition has always considered death and dying as a process. Indeed, unlike many religious traditions, Islam does not recognize death-bed conversions. The reason seems to be that in the dying process God has already willed that one's life has ended, and thus the opportunities of this life are past. When a person is in the process of dying, the period of life is over and the process of dying has begun. In addition, if a person has been fatally attacked, but has not yet died, they fall legally into an intermediate stage of either a "lingering life" if the person remains conscious or an "expiring life" if consciousness has been lost. The Sharia treats these people as the same as dead for purposes of determining responsibility, "blood money" (or compensation), and retaliation. In addition, under the doctrine of "death sickness" the terminally ill no longer have legal capacity to make important legal transactions. The idea of an intermediate stage between life and death has thus long been part of Islam. The Quran clearly marks the significance of death in the divinely given soul leaving the body. The definition of death is thus the separation of the soul from the body[19]

As a conceptual matter, the idea that you can have human biological life without the soul present is reflected in the process of fetal development discussed above. As we have seen, according to the most common interpretation of the Quran and Hadith, the body is ensouled after 120 days. By clear analogy, the body could also be maintained and still "alive" in a biological sense after the soul has left. Although brain-death is still a disputed concept in Islam, there is conceptual space for the concept of brain-death, and even higher-brain death, as the "sign" of the death of the person. The traditions of Sharia

[19] Brigit Krawietz "Brain Death and Islamic Tradition," in *Islamic Ethics of Life* edited by Jonathan E. Brockopp (University of South Carolina Press, 2003); pp. 206-7.

interpretation mention certain "signs" of death, as distinct from the concept of death as the separation of soul and body. The signs include "the glazing of the eyes, stopping of breath, parting of lips, relaxation of the feet, bending of the nose, or caving in of the temples … if there was any doubt the body had to be left untouched until it began to smell."[20] These are simply common signs of death, however, and they are not based on the Quran or Hadith. When the signs of death are indeterminate, the decomposing body is said to be the only certain sign of death. Thus the criteria for declaring death are not fixed by the Sharia.

The basis of Islamic resistance to the concept of brain death seems to be based, first, on a common reluctance across cultures to give up traditional means of determining death combined with, second, a tendency to focus on the more controversial concept of higher brain death, as opposed to the now common and widely accepted concept of whole-brain death.[21] In theory, the reluctance to give up traditional signs of death actually should be less of an obstacle for Islam than in other cultural contexts because of the clear distinction long recognized by Muslims between the *signs* of death and the *concept* of death as the loss of the soul. Since death was never defined as cardio-respiratory activity, changing to the use of brain death criteria is a smaller revision than in Western countries. Although many may be reluctant to adopt modern medical criteria, there is no Sharia barrier to *biomedical criteria* and there is a clear conceptual distinction already in place between criteria of death and death itself, which is consistent with the use of "better" criteria.

Others object more directly to the criteria determining brain-death itself, and here we see that these arguments often identify "brain-death" with the more controversial standard of higher-brain death, that is, with a persistent vegetative state (and not the now common international standard of whole-brain death). More specifically, concerns expressed about the uncertainty of the diagnosis of whole-brain death, on the basis of claims that people have *recovered* from brain death, are based on first confusing whole-brain and higher-brain death, and second, with the previously poorly understood nature of minimally conscious states as opposed to persistent vegetative states (discussed in chapter IV). Of course, as a conceptual matter, one cannot recover from brain-death because it is the irreversible loss of brain function. More importantly, as a scientific matter, the criteria establishing brain death become ever more sophisticated, and even higher-brain death can be conclusively established in particular cases. There is, however, no possibility of recovery of consciousness from a diagnosis of whole-brain death. Indeed, it is part of the criteria of whole brain death that the brain stem has died and so the body cannot be maintained except by artificial means.

Finally, Islamic objections to the concept of brain death often emphasize the dignity of human life even in a persistent vegetative state, and here again we see that the objection is directed at higher-brain death that focuses on the irreversible loss of consciousness. Although, as we have seen (in chapter IV), there are indeed still those who object to the concept of whole-brain death and who argue for a return to traditional signs of death, these are not reasons distinctive to the Islamic tradition in any way. On the other hand, there is much in the Islamic tradition that identifies distinctly human life with the capacity for reason, will, and consciousness, which thus supports a higher-brain

[20] Krawietz p. 199.
[21] For a summary of Islamic arguments against brain death, see Krawietz p. 200-01.

approach to declaring death. In short, there is no truly distinctive Islamic approach to declaring death. The range of issues, arguments, and options mirror the issues that have surrounded brain death from the start. Since there is room for a range of reasonable opinions on this issue, according to tradition, individual Muslims should be able to decide for themselves on what is the most reasonable approach to take, and thus a "pluralist approach" to declaring death (as explained in section ??) is consistent with Islamic ethics

42. Organ Donation: Desecration, Charity, and Necessity

A fundamental principle of Islamic ethics (or Sharia) is the **principle of necessity**, which states that *necessity makes permissible the prohibited*. Since "God desires your well-being not your discomfort" (Q 2:185), and in circumstances where there are serious consequences to life, health, or well-being particular prohibitions that would block life-saving action or cause serious harm do not apply. Of course, applying the principle of necessity requires judgment and is context and situation specific. One must consider the significance and point of the prohibition as opposed to the beneficial consequences of an infringement, and decide if the prohibition is waived in that particular context. This principle inevitably plays a significant role in matters of life and death, and it is thus a central principle of Islamic medical ethics.

For example, as in all cultures, Muslims are required to show respect for the dead, and the Quran and Hadith clearly prohibit the desecration of a corpse. In addition, the Sharia provides clear directions on a respectful Islamic burial. Removing organs for transplant at least on the surface seems to clearly violate the usually norms governing respect for the dead, and it thus clearly raises the question of whether removing organs is an act of desecration and thus prohibited. The history of organs transplants across all cultures has involved the slow acceptance of the clear difference in intent, and thus in the moral character of the act, between life saving organ donation and desecration. Similarly in Islam, organ donation may be permitted simply because it saves human life. It is common to maintain that intent matters, and thus organ donation is a clear act of charity and not one of desecration at all. To others, however, organ transplants seem to treat the human body as a mere thing and not a priceless gift, and they thus resist the appeal to charity as a justification to violate the integrity of the dead body.

Assuming that we do have a clear conflict between duties of charity on the one hand and of preserving the integrity of the bodies of the dead on the other hand, the principle of necessity provides a clear basis for waiving the normal requirements for the respectful treatment of the dead. Indeed even if one continues to feel that "harvesting" organs infringes normal prohibitions, the necessity of saving life and reducing suffering makes permissible what otherwise would be prohibited. If organ donation is the only way to preserve life, then it is permissible. Indeed, organ transplants are somewhat analogous to the permission to preserve health or life through the use of otherwise prohibited liquids, foods, or drugs. In general a lesser injury is to be preferred to a greater injury, and so as long as the injury to the donor is less than the injury to the recipient, the organ donation is permissible. As long as there is a clear chance of a significant benefit, the concern for the living is the important consideration.

Some religious scholars have gone so far as to argue that organ donation, as a life saving act of charity, is required of Muslims. In the Quran, we are told "if anyone saved a life, it would be as if he saved the life of the whole people" (Quran 5:32). And in the

Hadith, Muhammad directs us to "seek a remedy for any disease" and organ transplants are a remedy for disease. Through the act of organ donation, perhaps we will contribute to saving a life, and thus we extend our charity even beyond our own death. On the basis of the general responsibility to save life, it is argued that the Muslim community as a whole should set up a system of organ donation and transplantation that strives to save every person in need.

Nonetheless other scholars continue to argue that organ donation is not permitted under the principle of necessity. "God does not like transgressors" and it is argued that organ donation is a serious harm to the donor and a transgression because it conflicts with the resurrection on the Day of Judgment. The Quran states that on Judgment Day "man's eyes, ears, and heart – each of his senses shall be closely questioned" (Q 17:36). From this some scholars insist that the body must be buried intact so that it can be fully resurrected and all of the senses can be questioned. Others respond, quite convincingly, that it is the use one made of one's senses that is to be questioned, and that this questioning is not undermined by organ donation. Furthermore, clearly an all powerful God can resurrect the body wherever it is located and however it is dispersed. Man cannot thwart the resurrection by merely transplanting organs. Furthermore, the "trust" that we must honor in caring for our bodies requires that we use our body wisely and bury them with due reverence. If donating an organ can save a life by being carefully transplanted into another person, then by saving a life and remedying disease it follows the principles of Sharia. If the rest of the body is properly buried, the trust to care for our bodies and return them with respect has been honored.

As a last point, the prohibition on the desecration of the dead occurs in the context of a prohibition on desecrating the bodies of one's enemies in times of war. The disrespect involved in such an act is so far from the context of donating an organ to save a life so as to be totally disanalogous. The context is totally different: one is an act of voluntary charity and the other is an act of aggression; the means is a careful medical procedure and not a violent mutilation; and the end is the preservation of life and not the vengeful rejoicing in the death of another.

Nonetheless, since many have reservations about organ donation, the decision to be a donor is a matter left to the judgment of the individual and the family. Muslims may carry donor cards and in the absence of a donor card, the family may consent for the deceased patient. Consistent with Islamic ethics, and the duty of the Islamic community to preserve life, a system of presumed consent and donor refusal, as outlined above, may in fact nicely capture Islamic ideals. [22]

[43. Buddhism, Death, and the Gift of Life]

To be added

[Conclusion -- to be added]

[22] For an excellent discussion of the issue of Organ Donation, see Vardit Rispler-Chaim, *Islamic Ethics in the Twentieth Century* (E J Brill Publisher, 1993); pp. 28-33. In 1996 the Muslim Law (Sharia) Council of the United Kingdom issued a *fatwa*, or religious opinion, on organ donation emphasizing the principles of charity and necessity. See http://www.bbc.co.uk/religion/religions/features/organ_donation/islam.shtml On the other hand, the Islamic medical ethicist and physician, Shahid Athar still prohibits cadaver organ transplants as desecration. See http://islam-usa.com/im18.html