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Joseph C. Howard

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Philosophical and Moral Issues of Organ Transplantation At the Close of the Twentieth Century

by

Rev. Father Joseph C. Howard, Jr.

The author is Instructor of Theology and Philosophical Medical Ethics at Loyola College Prep, Shreveport, Louisiana

The last several decades have witnessed a revolution in modern medicine through the transplantation of organs to preserve and extend human life; yet, this revolution has not been and is not without significant philosophical and moral responsibilities. Who would have dreamt that within this last decade, procedures such as heart transplants can in many cases be classified as ethically "ordinary" and allow a person to essentially live out his life expectancy. This paper will examine the moral principles employed by the Church, philosophers, and moral theologians and under what conditions organ transplants are considered either morally licit or illicit and why. The critical shortage of available organs for transplantation along with current proposals will be analyzed. The current use of clinical brain death criteria to establish that a patient is in fact dead will be analyzed as related to the procurement of the organs from the patient. The issue of using Anencephalics for harvesting organs will be analyzed. This will also be applied to the status of patients diagnosed with Persistent Vegetative State (PVS). The current status involving the use of fetal tissue obtained by induced abortion for transplantation will be presented with moral analysis. Finally, a case study will be presented which examines the ethics of conceiving a child for the purpose of saving the life of a sibling through transplantation.

Basis For Church Teachings

The general moral principles used by the Church in evaluating the transplantation of organs are rooted in Sacred Scripture, Sacred Tradition, and the Natural Law. The law of fraternal charity establishes that one's neighbor is to be regarded as another self and is based on the natural and supernatural unity of mankind. That Jesus offered Himself unselfishly is the basis that we as Christians should be inspired to offer ourselves in order that others have life.

Transplantation presupposes a prior, explicit, free and conscious decision on the part of the donor or someone who legitimately represents the donor, generally the closest relatives. A person can only donate that part of self by which he can deprive himself without serious danger or harm to his own life or identity and for just and proportionate cause. Obviously, an entire vital organ can only be donated after death. The body can never be treated as a mere biological entity; nor can its organs or tissues ever be used as items for sale or exchange. Such reductive, materialist conceptions exploit the person and assault his dignity. The contemporary and widespread effects of abortion and euthanasia in our society remind us of the potential of horrendous abuses which can occur regarding organ transplantation. Love, communion, solidarity and absolute respect for the dignity of the human person constitute the only legitimate context of organ transplantation (Transplantation and Immunology Letter, 2).

That there is a critical shortage of available organs for transplant is all too obvious. For example, it is estimated that over 30,000 Americans are on national waiting lists for some type transplant. In 1992, 8,500 patients received a kidney transplant, leaving 24,000 patients on a nationwide waiting list (Hargroder, interview). The question is often raised as to how more organs for transplantation can be obtained. One instance involved the kidnapping of a young male who was found in a hotel room after one of his kidneys had been surgically removed (Carmody, interview). Even though it is currently against federal law to engage in interstate commerce involving human organs (42 USC 2741e), some today propose this as a solution to the shortage. Dr. Thomas Peters of the Transplant Center in Jacksonville, Florida argues that payment to families for cadaver organs might bring more organs to the underprivileged. He proposes a death benefit payment of \$1,000 to the family, presumably as a legalized exception to the present law (O'Donnell, 35). This proposal must be rejected on philosophical and moral grounds in that it reduces the human person (who is dead) to the level of an object which is exploited and therefore damages his dignity. Even after death, the body of the deceased must be respected (Ratzinger, 18). Another proposal which is starting to gain momentum to increase availability of organs for transplant is that of "presumed consent." In this instance, organs may be removed from the patient after death as long as the patient did not expressly forbid it. This is again intrinsically wrong because it violates the free and conscious decision to give of oneself after death — a basic principle upon which the foundation of all medical ethics rests. At the very minimum, the free and informed consent of someone who legitimately represents the donor — generally the closest relatives — must be obtained before such procedures are undertaken.

The establishment of death using both higher and lower brain death criteria is critical before organs can be licitly harvested. In 1968, the *Ad Hoc Committee* of Harvard Medical School published criteria to establish death of the person by verifying total and irreversible death of the higher and lower brain. These criteria generally included irreversible cessation of spontaneous respiratory and circulatory functions and/or the use of specific, clinical criteria such as the testing of specific reflexes, along with the use of an electroencephalogram (EEG). These criteria, which were first published in 1968, have until recently been accepted

unanimously by the medical profession in ascertaining the authentic death of the patient. It has only been recently that there have been efforts to declare a patient dead or his life "not worth saving" despite the fact he is not suffering from total and irreversible death of the higher and lower brain.

The application of the criteria from the *Ad Hoc Committee* of Harvard Medical School is used to verify that there is no evidence of the entire brain whatsoever functioning. For example, the EEG is a measure of cortical activity. An isoelectric EEG does not give information regarding the brain stem. Cortical functions include consciousness and the abilities to learn and respond; functions of the brain stem include the regulation of cardiac rate, blood pressure, body temperature, blood sugar balance and endocrine function, especially thyroid and adrenal activity (Guyton, 195-202). It should be noted that there have been cases documented of absence of all brain stem reflexes, respiratory failure, and coma but with preservation of EEG activity and recovery (Bolton, 535). There is, unfortunately, a significant trend today in our society to declare a patient dead who is not totally and irreversibly brain dead — either there is evidence of cortical functioning without evidence of brain stem functions or vice-versa. In either case, the patient is not dead because there is still spontaneous evidence of the brain functioning, which indicates the intrinsic presence of the soul.

While only cortical functions can be assessed by the use of an EEG, specific reflexes must be evaluated to determine if the brain stem is intact. Byrne and Nilges report that the only way one can adequately evaluate the entire brain stem is to study it "layer by layer." This can only be done by evaluating the known brain stem reflexes: pupillary, corneal, grimace, jaw, spontaneous, eye motions, oculocephalic, oculovestibular, oculocardiac, acoustocardiac, gag and cough, carotid sinus, esophageal, and ciliospinal. Along with testing of these 14 known brain stem reflexes, Byrne and Nilges also call for the Apnea Test (Byrne and Nilges, 3-21).

Byrne and Nilges call for an urgent dialogue to be reopened on brain death. They argue that the usual orientation which searches for signs of brain death should be reversed where physicians look for signs of brain life in order to avoid pronouncing a live patient dead. This is the application of a basic rule of medicine: *primum non nocere*, first do no harm. While these physicians realize that they are disputing a current trend, they recognize their responsibility is to the patient entrusted to them. As a result, they most appropriately advocate that the original Harvard recommendations be followed. All brain functions must be irretrievably lost. The observation period should be at least 24 hours and the following criteria should be strictly adhered to: All brain stem reflexes should be tested and found absent and the reflexes retested after twenty-four hours; there should be two isoelectric EEGs separated by a twenty-four hour interval, and the critical apnea test must be carefully done with no respiratory activity demonstrated. It is my position that only when all of these criteria have been strictly met can we then discuss the possibility of organ transplantation from a prospective donor that is morally licit.

Recent times have witnessed a growing desire to harvest organs from infants born with Anencephaly. This disorder results from a failure of the neural tissue to completely close at the cephalic end of the developing child. Even though many

may conclude that an Anencephalic has no brain, functioning neural tissue is always present — the brain stem is present (Byrne, Evers, *et al.*, 22-33). The underlying philosophical assumption here is that a human life is not present if a human brain is not present. We will demonstrate the philosophical errors of this assumption as applied to the Theresa Ann Campo case of Fort Lauderdale, Florida.

Theresa Ann Campo was diagnosed antenatally with Anencephaly. Preparations were made to harvest her organs following birth. Studies indicate that transplants from Anencephalic donors are frequently unsuccessful because of organ deterioration preceding the time of death. Also, the standard criteria used to establish brain death are virtually impossible to apply to Anencephalic infants. After her birth, Theresa Ann was intubated and received ventilatory support. One week later the ventilator was removed and she breathed on her own for a period of time, clearly indicating that the brain stem function governing spontaneous breathing was intact. Other brain stem functions controlling heart rate, blood pressure, salt and water balance, pituitary - endocrine organ functions, as well as many other organs and systems were recognized to be intact and functioning in Theresa Ann's body (Byrne, Evers, *et al.*, 24). Theresa Ann Campo was born as a living human being though with a serious congenital defect.

The case of Theresa Ann Campo went before the judicial system due to the conflict of wanting "to declare her dead" in order that her organs could be harvested even though she was not totally and irreversibly brain dead. Relevant to the application of the civil law is the Uniform Determination of Death Act (UDDA) set forth by the President's Commission for the Study of Ethical Problems in Medicine and Bioethical and Behavioral Research. The UDDA recognizes that an individual is not dead unless he or she has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. The Florida Supreme Court affirmed the lower court's ruling that there cannot be a legal determination of death so long as the brain stem continues to function.

The infant with Anencephaly is a living human being despite the fact there is a serious congenital abnormality which is usually associated with short term survival. The Anencephalic is dying but not yet dead. To remove vital organs from the Anencephalic before death is morally murder just as it is for any other human being. The current philosophy in American society is reflected in utilitarianism — the greatest good for the greatest number — which must be rejected. Even if an infant with Anencephaly will die within hours and five other infants can be saved by harvesting organs preceding total and irreversible brain death of the Anencephalic, from a moral perspective there has been an act of deliberately and intentionally taking of the life of an innocent human being: murder. As Byrne, Evers and Nilges report, creation of a fictional category of death for Anencephalic infants to harvest their organs is not only medically dishonest, it is morally reprehensible (Byrne, Evers, *et al.*, 23).

Patients diagnosed with Persistent Vegetative State are seen many times to be in a unique category as regards organ transplantation. Usually, the brain stem is relatively intact yet the cerebral hemispheres suffer irreversible damage. The

patients typically breath spontaneously, their eyes open and respond normally to light, and periods of sleep will occur. While the protective gag, cough, and swallow reflexes are usually normal, all voluntary reactions or behavioral responses reflecting consciousness, volition, or emotion at the cerebral cortical level are absent. These patients are clearly not suffering from total and irreversible death of the entire brain. In fact, they may survive for years, if not decades (Mitchell and Lovat, 83).

In recent times, the American Academy of Neurology adopted a position regarding the care and management of the patient diagnosed with PVS. In 1986 the Academy stated that pain and suffering are attributes of consciousness and patients diagnosed with PVS do not experience them. Noxious stimuli may activate peripherally located nerves, but only a brain with the capacity of consciousness can translate that neural activity into an experience (Cranford, 33-7). In 1988, the Executive Board of the American Academy of Neurology adopted the position that the diagnosis of permanent unconsciousness can usually be made with a high degree of medical certainty in cases of hypoxic-ischemic encephalopathy after a period of one to three months. The position adopted by the Academy is that artificial nutrition and hydration are a form of medical treatment and may be discontinued in accordance with the principles and practices governing the withholding and withdrawal of other forms of medical treatment. The Academy concludes that medical treatment, including the provision of artificial nutrition and hydration, provides no benefit to patients in a PVS, once the diagnosis has been established to a high degree of medical certainty (American Academy of Neurology, 1-5). It is known that the withdrawal of all nutrition and hydration will result in death within a few weeks (Blanchet, interview). Some in our society today propose that these individuals would be ideally suited to donate their organs in order that a number of other lives be saved.

The current trend of promoting the withholding or withdrawing of artificial nutrition and hydration in patients diagnosed with PVS has significant moral relevance especially as related to organ transplantation. It is necessary to recognize that it is possible to kill a person by acts of omission (passive euthanasia) or acts of commission (active euthanasia). We must recognize that the deliberate denial of food and water to innocent human beings in order to bring about their deaths is homicide for it is the choice to kill by starvation and dehydration. Such killing is seriously immoral and should never be legalized (May, Barry, *et al.*, 203-211). This type of killing sanctions status-based discrimination based on the debilitated physical or mental condition of the person. The fact that the killing is done by an act of omission makes it no less reprehensible. Unfortunately, many in our society today invoke the philosophy of utilitarianism as an answer to this conflict. They want to "get rid of the patient" diagnosed with PVS because he or she no longer serves any useful purpose to others or society. Again, they think of saving several lives from harvesting the organs of the patient with PVS since they fail to recognize that there is still an intrinsic value and dignity present in these patients as there is in all other individuals. To kill a patient with PVS by removing vital organs before there is total and irreversible brain death or by starvation and dehydration is intrinsically evil no matter how many lives can be saved. One may

never directly perform evil in order that good come out of it. These underlying philosophical trends are already being extended and applied to individuals with strokes, Alzheimer's disease, organic brain syndrome, and AIDS dementia to name but a few. We are being forced to answer whether individuals who are terminally ill and dying or those who "no longer serve a purpose in society" still are created in God's image and possess intrinsic dignity and are worthy of our love, compassion, and understanding or whether we should cooperate in ending their lives, an act which would be morally considered murder.

Recent times have tried to bring good out of the tragedy of abortion by using fetal tissue to treat adult disease by transplantation. On January 22, 1993, the Clinton Administration lifted the ban on federally funded research involving the use of fetal tissue for the treatment of adult disease. While many today see abortion for what it truly is, the murder of an innocent and unborn child, they question whether or not it is morally licit to utilize the remains of fetal tissue obtained by induced abortion. It is very common to hear individuals say that once the tragedy of abortion has already occurred, we might as well try to bring some good out of it by helping others.

One of the contemporary methods being proposed to treat Diabetes Type I (insulin dependent) is by the use of the pancreas of fetuses obtained by induced abortion. Currently, there are approximately 1.4 million diabetics in the United States with 30,000 new cases diagnosed per year. In an effort to relieve the diabetic of repeated insulin injections, proposals have been made "to cure diabetes" by pancreatic fetal transplantation into the diabetic. To accomplish this, there must be at least eight fetal pancreases obtained at 14 to 20 weeks of gestation by induced abortion. Note that fetal tissue from a spontaneous miscarriage cannot be used and most of this tissue has chromosomal aberrations; fetal tissue must be obtained and used 3-5 minutes after induced abortion or it is worthless. In the United States, approximately 120,000 abortions per year are performed at 14-20 weeks (Nathanson, lecture). Based upon this, there would be a shortage of twelve million fetuses "to cure" all diabetics. Where will the additional twelve million fetuses — and therefore abortions — come from and be performed?

The management of patients diagnosed with Parkinson's Disease is now also being confronted with using fetal brain tissue obtained by induced abortion. There are 500,000 victims in the United States today with this disorder along with 40,000 new cases per year. Similar to this are the four million individuals in the United States with Alzheimer's Disease along with 250,000 new cases per year. To attempt transplantation for either Parkinson's or Alzheimer's, there must be at least five fetuses obtained by induced abortion at 9-12 weeks of gestation. Given the number of abortions performed in the United States annually at this gestation period, there would be a shortage of 1.7 million fetuses in treating Parkinson's Disease alone (Nathanson, lecture). Again, where will the additional millions of fetuses — and therefore abortions — come from and be performed? The demand is great yet, the supply insufficient for now.

The scientific, philosophical, and moral implications of this technology are horribly frightening and critically relevant. It is most relevant to realize that the use of fetal tissue to treat adult disease in terms of success has been very disappointing.

There has been a very dismal history in the past as well as in the present. For instance, one study of patients with Parkinson's Disease who underwent transplantation of fetal brain obtained by induced abortion drew conclusions based upon only 13 participants. The scientific method in pursuit of truth requires that adequate numbers of individuals be evaluated before authentic scientific conclusions can be drawn (Nathanson, lecture). The philosophy of this technology is again rooted in utilitarianism which argues for the greatest good for the greatest number. We can only imagine the enormous emotional appeal that will be used to help women who are contemplating an abortion or, even worse, given remuneration for having the abortion, deal with their guilt with the counsel that by their having an abortion a number of lives can be restored from the horrible suffering of Parkinson's or Alzheimer's. Moral theology recognizes that it is never permissible to directly commit evil acts in order to bring about that which is good. Who does not find it morally reprehensible that an abortionist is killed with the motive of saving thousands of innocent lives of the unborn? Secondly, all deliberate, induced abortions are intrinsically evil regardless of the motive because they destroy innocent human life, which is morally murder. Just as it is wrong to freely and knowingly utilize any goods which are obtained illicitly to bring about good, so does the Church condemn the proposition of using fetal tissue obtained by induced abortion with the motive of achieving good (Ratzinger, 18). In the classical notion of moral theology, this is scandalous behavior and is gravely sinful. It is horrifying that the idea of constructing fetal farms and fetal tissue banks is presently under consideration. We have every reason to believe that the number of abortions will increase dramatically because of this technology. An international fetal farm market can easily be set up in the economically disadvantaged parts of the world — the third world — as well as countries already practicing abortions in large numbers, such as China. We can only ask what it will take to have society recognize the philosophical parallel between this technology and the holocaust in Nazi Germany?

In 1991, a child was conceived by her parents with the motive of transplanting bone marrow to a 19 year old sibling suffering from leukemia. Anissa Ayala was suffering from terminal leukemia. Though Mr. and Mrs. Ayala desperately tried to find a compatible bone marrow donor, they were not successful. As a result, they conceived a child with the hope that the bone marrow would be compatible and could be transplanted to the sibling Anissa. The bone marrow was compatible and on June 4, 1991 a bone marrow transplant was performed.

The orthodox philosophical and moral analysis of conceiving a child for the primary purpose of bone marrow transplant needs to be thoroughly understood and implemented in society. Though it is true that the Ayalas agreed to love and care for the conceived child even if the bone marrow was not compatible, it does not change the fact that the child was primarily conceived as a means to an end. Christians are called to recognize that all human beings are ends in themselves and that anything which treats a person as a means to an end exploits the person —thereby showing a lack of respect for that person. One can easily see how attempts like this could in theory easily lead to screening for compatibility *in utero* and aborting the unborn if he or she is in fact not compatible. Also, we must recognize that there was a violation of free and informed consent. No person —

including the child's parents — have the moral right to save the life of another child. We can only imagine the injustices which could be committed by decisions to "volunteer" organs and tissues from those who are either temporarily or permanently incompetent: the unborn, young children whose intellects have not fully developed, the retarded, the elderly, and those terminally suffering. The philosophy of utilitarianism is again present in this case. No matter what good may come out of such a procedure, it is morally incorrect since the person conceived is treated as a means to an end and there is a violation of free and informed consent.

The potential to restore life by organ transplantation is remarkable; however, there are serious potential abuses and injustices. Since the 1973 United States Supreme Court decision of *Roe v. Wade*, our society has not consistently upheld the fact that all humans possess intrinsic value and dignity not because of how useful one is but due to how God created human life in His own image. Current trends in American society reflect philosophies of significant individualism and utilitarianism which we must reject in all forms since they are incompatible with Christianity. There is a call to all Christians and men and women of good will to receive the authentic moral teachings of the Church on the issues of organ transplantation. We are reminded that we continue to hear Christ speak to us as He promised: "Whoever hears the Church, hears Christ. Whoever rejects the Church, rejects Christ. And whoever rejects Christ, rejects the Father" (New American, Luke 10:16).

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