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Organ transplantation from the deceased has proven to be very successful. Yet so short is the time interval between the cessation of living of the deceased and the beginning of organ transplantation that some earlier evidence invites intellectual dishonesty. It might even be said to invite murder.

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

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

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

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

Death, as stated above, denotes the irreversible end of a biological structure as a whole. What is meant by "biological structure as a whole"? It is a whole which we consider adequately described only as subject (not merely object), a center of spontaneity or autonomy in contrast to a structural whole that needs no such characterization, e.g., a machine. Biological whole also means that it is a whole not at any moment of its existence but only in time, similar to a non-biological dynamic whole, e.g., a thunderstorm. (Since the developing and maturing of a biological whole is subject-born a biological whole transcends the merely reactive dynamism of a non-biological whole but that does not concern us in this context.) However, for the purpose of describing men as a biological whole the two above characterizations do not suffice. To be sure man is a center of spontaneity, someone, not merely something. Surely he is a developing being like the rest of the objects of our experience that we call living. But, as we all agree, he is not merely a center of urges and instincts. He is more. In the period of his greatest autonomy he is aware of his status. He "desires to know, he wonders why things are as they are." He is a conscious (which literally means: knowing "with" one's self), reflective, responsible being.
relevant. For man, one might say, may die as man, long before he dies as a biological being. If neurologists or other experts tell us that they have found some incontestable signs of a person having irreversibly lost consciousness, as indicated, for instance, by the absence of E.E.G. waves over a certain length of time we might well agree that such an individual as a man has indeed died.

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

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

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

References
3. Thompson V. Deeds, 93 Iowa 228, 61 N.W. 842 (1895).

Caring
Robert E. Fredericks, M.D., F.A.C.P.

Two common words in our language are "for" and "about". They are usually thought of as simple consecutive prepositions. An important word in our profession is the word "care". But it's amazing what a difference in meaning results, depending on which of the simple prepositions follows that word "care". The difference is not just in meaning, but much more important, a difference in loving.

I've been racking my brain for weeks trying to find a way that I can talk to you about loving. I have been tempted to use all the obvious clichés. I have fought the annoying tendency to philosophize and theorize about love. I have been concerned that it would seem that I am trying to deliver a sermon to you, who are probably better practitioners - both of medicine and of loving - than I am. Finally it occurred to me that perhaps we could share some of the problems with which I have struggled in this sensitive area and find out how we can care more about our patients - beyond just caring for them.

Where do we start? To whom do we look? The theologians and philosophers? The psychiatrists and psychologists? Yes, they can all help, but their views are often impersonal or sometimes directly in conflict. How about the poets and novelists? Perhaps they tell us more, or at least they move us more emotionally. Where else to look? Perhaps to Lincoln, Gandhi, Schweitzer? All great and loving men - but for us, the man who cared most and did most ABOUT others was certainly the Carpenter of Nazareth. It's of special interest to us that He has so often been credited with being the "Great Physician", not because of his advanced medical knowledge or scientific skill, but in praise of his loving care ABOUT all of his "patients".

Like you, I am a Christian, and that's important. But in practice and daily preoccupation, I seem to emphasize my role as doctor far above my role as Christian. I'm beginning to realize more deeply how it matters to me as a doctor and how important it is for my patients that I re-order these priorities. I need to do as much caring ABOUT as I have done caring FOR.

A friend of mine loves to introduce into any discussion of Christ, the good humor and broadminded humanity of