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All of Me, Saves All of You: A New Approach to Organ Donation by the Imminently Dying and Consenting Individual

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ALL OF ME, SAVES ALL OF YOU: A NEW APPROACH TO ORGAN DONATION BY THE IMMINENTLY DYING AND CONSENTING INDIVIDUAL

I. Introduction:

Twenty-two people die each day waiting for a lifesaving organ.[1] There are approximately 100,000 patients on the donor list, yet there are only 14,000 registered donors.[2] Some scholars addressing the shortage focus on increasing donor registration. Proposals include presumed consent, mandated choice, and financial incentives for a donor or their family.[3] However, even if those proposals were widely accepted, which they are not, the deeper issue affecting the number organ donations has less to do with the number of registered donors and everything to do with the the rules surrounding organ procurement. When the hospital identifies a potential donor, the physician must first confirm consent by the family.[4] In fact, this is the case even when the person is a registered donor.[5] Once that difficult and time-sensitive hurdle is cleared, a physician must abide by the Dead Donor Rule before organ procurement can take place.[6]

II. The Issue: Organs of Consenting Individuals Are Lost due to the Dead Donor Rule

The Dead Donor Rule is an ethical norm which holds that vital organs should only be removed from dead patients and relatedly, that living donors must not be killed by organ removal.[7] For the purposes of this article, the focus lies on living patients who consent to organ donation,

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[1] Hennepin Healthcare Research Institute (HHRI) and United Network for Organ Sharing (UNOS), Organ Procurement and Transplantation Network (OPTN) and Scientific Registry of Transplant Recipients (SRTR). OPTN/SRTR 2017 Annual Data Report (November 27, 2019 1:45pm), https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/

[2] Id.

[3] Id.

[4] Id.

[5] Id.

[6] OPTN/SRTR 2017 Annual Data Report

[7] Laura-Hill M. Patton., Note, A Call for Common Sense: Organ Donation and the Executed Prisoner, 3 Va. J. Soc. Pol'y & L. 387, 403 (1996).

either individually or through family. These may include patients who face imminent death or suffer severe neurological injury.[8] The Dead Donor Rule requires death before procurement, leaving a pool of potential consenting donors.[9]

III. Proposal for Increasing Donor Donations:

This article proposes eliminating the Dead Donor Rule in order to allow procurement once a patient faces imminent death and has consented to organ donation. Some may argue that abolishing the Dead Donor Rule would allow a physician to, in effect, kill a patient for their organs.[10] Further, they may argue this contradicts the most fundamental tenet of the medical practice, embodied in the Hippocratic Oath, "first, do no harm."[11]

However, this article challenges today's static understanding of what it means to do no harm. In some cases, and specifically for many patients facing imminent death, keeping them alive beyond their wishes is doing harm. Relying the utilitarian theory, that the most ethical choice will produce the greatest good for the greatest number, there is reasonable justification in allowing someone who is imminently dying to hasten their own death by providing many others with life-saving organs.[12]

IV. Background:

The Development of Brain Death:

[8] Id.
[9] Id. at 388
[10] Ben Bronner, *Lethal Organ Donation: Would the Doctor Intend the Donor's Death,* JOURNAL OF MEDICINE AND PHILOSOPHY, 442,445 (2019)
[11] Id.
[12] Id. at 450

The turn of the century welcomed advances in medicine and technology that demanded a reevaluation of how society defined death.[13] At the time death was defined as, "an individual who has sustained irreversible cessation of circulatory and respiratory functions." The polio outbreak left patients with paralyzed muscles in their chest unable to breath.[14] At the same time, surgeons began using muscle relaxants with anesthesia to improve operating conditions.[15] The combination had a paralyzing effect on a patient's respiratory muscles.[16] This led engineers to inventing the iron lung and later a mechanical ventilator.[17] Suddenly, patients that would have died due their inability to breathe were maintained, and wholly dependent on the ventilator.[18]

In addition, the ventilator kept patients with varying degrees of brain damage alive in different stages of consciousness. This raised ethical concerns among physicians who noted patients with zero brain activity, who showed no signs of recovery, but received continued treatment.[19] These patients expended medical resources but their conditions remained unchanged.[20] Finally, even if a physician believed treatment was futile, they could face homicide

[13] Robert D. Truog, MD, MA; Thaddeus Mason Pope, JD, PhD; David S. Jones, MD, PhD, *The 50-Year Legacy of the Harvard Report on Brain Death*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 335, 335 (2018).
[14] Emerson, John H (1998). *Some Reflections on Iron Lungs and Other Inventions* RESPIRATORY CARE, 575 (1998).
[15] Id.
[16] Id.
[17] A. Barrington Baker, *Artificial Respiration: The History of an Idea*, MEDICAL HISTORY, 336, 336, (1971).
[18] Robert D. Truog, *Brain Death - Too Flawed to Endure, Too Ingrained to Abandon*, 35 JOURNAL OF LAW, MEDICINE & ETHICS, 273, 276 (2007) (discussing the philosophical and societal dilemmas of labeling a breathing human being as deceased).
[19] Sigrid Fry-Revere, Thomas Reher and Matthew Ray, *Death: A New Legal Perspective*, 27 J. Contemp. Health L. & Pol'y 1,7 (2010).
[20] Id.

charges for removing the life-sustaining ventilator.[21] At the time this was the only law applicable which prevented physicians from intervening with life-sustaining treatment.[22]

A New Category for Determining Death:

The futility of rendering care for these patients combined with demand for organ transplantation motivated scholars to revaluate the definition of death. Therefore, in the fall of 1967, Henry Breecher, an anesthesiologist at Harvard Medical School gathered an ad hoc committee to consider, "the ethical problems created by the hopelessly unconscious patient."[23] The committee stated that its purpose was to:

> decrease the burden on families of keeping a person on continued medical support who had irreversible brain damage, and to facilitate the recovery of organs from such people because they were dead, not under traditional circulatory criteria, but under the new definition of brain death.

AD HOC COMMITTEE, supra note 47, at 85.

The committee produced a landmark report which included the criteria for determining when a patient was considered in an irreversible state that constituted brain death.[24] This came to be known as the "Harvard criteria" for determining brain death.[25] It noted that a physician had to determined over a 24-hour period that the patient did not respond to stimuli, had no spontaneous movement, breathing, reflexes, and a flat electroencephalogram.[26] The report clarified that a physician could now declare a patient dead prior to organ procurement, thereby allowing organ procurement when organs are in an optimal condition.[27]

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[21] See JOURNAL OF LAW, MEDICINE & ETHICS, *Supra.* n.18.
[22] Id.
[23] JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, *Supra* n. 13
[24] JOURNAL OF LAW, MEDICINE & ETHICS, *Supra*, n. 18
[25] JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, *Supra.* n.13.
[26] Id.
[27] Id.

While the committee's report was accepted in the medical community, it lacked the force of law.[28] As states adopted a patchwork of the Harvard criteria, it became confusing that a person could be legally dead under the criteria one state but alive in another.[29] Theoretically, a physician in a state that adopted the brain death criteria could pronounce a patient dead, only to have the patient's family drive across state lines where the patient would be "revived". This posed issues for physicians who declared patients dead but faced resistance and potential liability from families of the patient.

In fact, the courts heard cases on this very issue, asking if: (1) law or medicine should define the standards of death; (2) brain death should be adopted; and (3) medicine should have any role in defining the criteria for determining those brain death standards.[30] In *Lovato*, a Colorado court held that a 17 month-old baby was properly declared brain dead following gross physical abuse.[31] The court discussed the development of resuscitative technology and the traditional definition of death as, "[w]hen a person's heart stopped beating and he stopped breathing, he was dead"[32] The court traced through advances in medicine to ultimately find that the brain death criteria was an acceptable model to be followed by the state. The following year, the Supreme Court of Washington heard a similar case regarding a physically abused five-year-old.[33] The physician declared the boy legally dead under the Harvard criteria for brain death .[34] The boy's guardian ad litem, requested the court enjoin the withdrawal of life support and filed suit

[28] Id.
[29] Id.
[30] See In re Bowman, 617 P.2d 731, 736 (Wash. 1980).
[31] Lovato v. District Court in , 601 P.2d 1072, 1073 (Colo. 1979).
[32] Id. at 1076 (quoting Wasmuth, Jr., *The Concept of Death*, 30 OHIO ST.L.REV. 32 (1969).
[33] In re Bowman, 617 P.2d 731, 733 (Wash. 1980).
[34] Id. at 410

challenging the hospital's declaration of death.[35] The court similarly relied on the development of brain death from the Harvard report and cited *Lovato* as support of the dual definition for death. The continued discrepancy across states confounded the medical and legal world. On the one hand, physicians accepted the medical definition for death which included brain death, but laws were silent on the issue.

In response, Congress created the President's Commission for the Study of Ethical Problems in Medicine to study the changing definitions of death.[36] In 1981, the commission produced a 166-page report which is now the Uniform Determination of Death Act.[37] This unofficial legislation served as a guideline to promote consistency among the states. States are expected to use the model act as the basis for the individual state's uniform law. The UDDA provides that:

> An individual who has sustained either (1) irreversible cessation 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.

Uniform Determination of Death Act, § 1, 12A U.L.A. 781 (2008).

Every state has since adopted a version of the uniform law, recognizing both criterion for determining death.[38] Four states in particular allow families to object to a declaration of death based on conscientious grounds.[39]

Existing Sources for Organ Donation:

[35] Id. at 408
[36] AD HOC COMMITTEE, supra note 47, at 85.
[37] Robert D. Truog at 336
[38] Thaddeus Mason Pope, Brain Death Forsaken: Growing Conflict and New Legal Challenges, J LEG MED, 37, 265, 277 (2017).
[39] For example, New Jersey and New York recognize a religious exemption to brain death.

Life Support Withdrawal Donors include brain dead patients and patients who do not meet the criteria for brain death but whose family decides to withdraw life-sustaining treatment.[40] The first group of Life Support Withdrawal Donors are brain dead patients.[41] The recognition of brain death as legal death invited a new wave of potential organ donors.[42]

A. Donation After Brain Death

Donation after brain death means organs are kept at an optimal condition through the body's continued circulatory function.[43] When a patient died under the traditional criteria organs faced potential damage by an increased ischemia time.[44] Ischemia is the inadequate blood supply to an organ.[45] This naturally happens when a patient's heart stops and therefore continues to be a concern for non-hearting beating donors.[46] For brain dead donors, the heart continues pumping blood and providing oxygen to the organs. Donation after brain death facilitated lung donations and made heart transplants possible.[47] Prior to this, a number of patients suffering from lung or hear- related failure had no option for life-saving treatment. For example, patients suffering cystic fibrosis can now join a organ donation list and receive life-saving lungs transplant.[48]

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[40] Wilkinson, Dominic, and Julian Savulescu, *Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation*, BIOETHICS 32, 33 (2012).
[41] Id.
[42] Id.
[43] Prolonged warm ischemia time (the time from organ removal from cold storage to reperfusion with warm blood) is associated with graft failure and mortality among kidney transplant recipients. Factors Associated with Prolonged Warm Ischemia Time Among Deceased Donor Kidney Transplant Recipients.
[44] BIOETHICS, *Supra*, n. 40
[45] Id.
[46] Id.
[47] Id.

Despite the medical and legal acceptance and application of brain death as death, some critics continue to object to brain death.[49] These are individuals who understand brain death as a concept but reject it either on medical or religious grounds. For example, some believe that a person is still alive because of their ability to perform a range of bodily functions.[50] A brain dead patient continues to "perform a range of integrative biological functioning, such as circulation, hormonal balance, temperature control, digestion and metabolism of food, excretion of wastes, wound healing, fighting infections, and growth and sexual maturation in the case of children" and in some rare cases pregnant brain dead women have gestated fetuses for up to 3 months.[51] Others may believe in what is known as a biological or organismic definition of death, which requires the irreversible cessation of functioning of an organism as a whole.[52] Under the standards outlined in the UDDA, however, a brain dead patient is legally dead.[53]

Rejection from the general public, on the other hand, likely stems from a lack of understanding and misinformation. Part of the problem is the cycle of misinformation fed through the media to the public.[54] Ever so often news stories claim a brain dead patient woke up from a

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[50] F.G. Millers, RD Truog, DW Brock, *The Dead Donor Rule: Can it Withstand Critical Scrutiny?,* J MED PHILOS, 229, 301 (2010).
[51] Id. at 301.
[52] E. Christian Brugger, *Are Brain Dead Individuals Dead? Grounds for Reasonable Doubt,* J. Med. Philos, 329,331 (2016).
[53] But See New Jersey Declaration of Death Act, N.J. Laws 90 (1991). Quoting (Unless the family objects to this determination on religious grounds and the state recognizes a religious exemption. The death of an individual shall not be declared upon the basis of neurological criteria pursuant to sections 3 and 4 of this act when the licensed physician authorized to declare death, has reason to believe, on the basis of information in the individual's available medical records, or information provided by a member of the individual's family or any other person knowledgeable about the individual's personal religious beliefs that such a declaration would violate the personal religious beliefs of the individual. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria pursuant to section 2 of this act.").
[54] Ariane Daoust, Eric Racine, *Depictions of 'Brain Death' in the Media: Medical and Ethical Implications,* JOURNAL OF MEDICAL ETHICS, (2013).

coma, effectively spewing out misinformation.[55] A study in 2013 aimed to find the identify how often news articles fail to distinguish brain death from other stages of unconsciousness.[56] The study gathered 519 news articles containing the words 'brain dead' or 'brain death' published between 2005 and 2009.[57] The study found that less than 3% of the articles defined brain death under the determination of neurological criteria and half of those used incomplete definitions.[58]

A 2004 study by Siminoff, Burant, and Younger surveyed over 1000 Ohio residents in an attempt to gauge public attitudes and beliefs about brain death and organ donation.[59] The survey presented patients in different stages of consciousness and asked for a personal assessment of whether the patient was dead and whether they were willing to donate that patient's organs.[60] The results found that over 98% of the respondents were familiar with brain death, but only 33.7% believed that someone who was brain dead was legally dead. A third of the sample were willing to donate the organs of patients that were brain dead, in a vegetative state, and even comatose patients.[61] The study illustrates that at least some people believe a lack of consciousness constitutes reasonable justification for organ donation.

Mistrust of the transplantation process also comes from myths about the procurement process and the rules that govern who can donate. A common misconception is that a physician will identify a registered donor in urgent care and render inadequate medical treatment to harvest their organs. However, the conversation regarding organ donation only begins after the family

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[55] Id.
[56] Id.
[57] Id.
[58] Ariane Daoust, Eric Racine at
[59] Laura A. Siminoff, Stuart J. Youngner, and Christopher Burant, *Death and Organ Procurment: Public Beliefs and Attitudes,* KENNEDY INSTITUTE OF ETHICS JOURNAL 217, 218 (2004).
[60] Id.
[61] Id.

decides to withdraw life-support. For brain dead patients, this is not an option because a brain dead patient is legally dead, and there is no need to remove life-support to make that determination. In order to confirm brain death there are a series of assessments required of the physician. The figure below illustrates the tests to determine brain death.

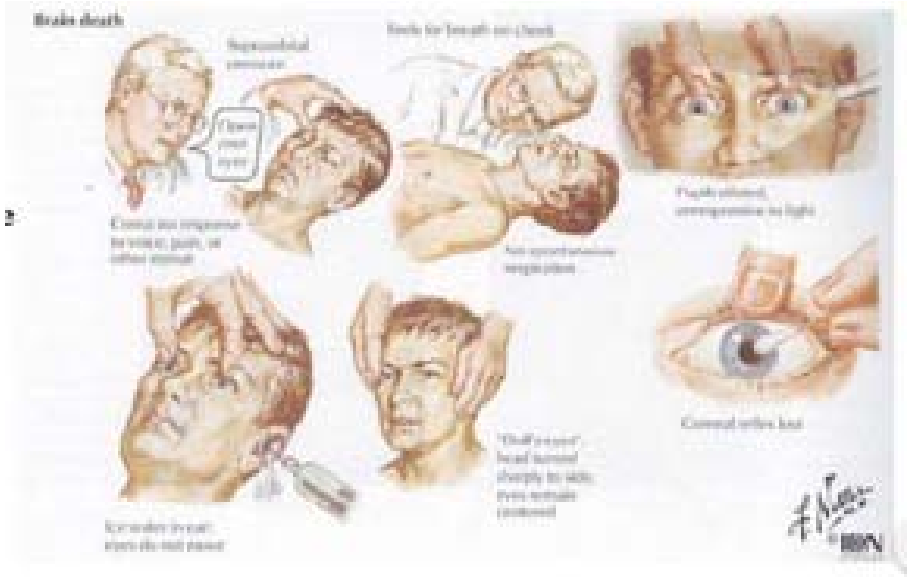


Figure 3. **Assessment of Brain death.** Adapted from Himmel-Diagnose, by F. Netter, 2013. Retrieved from http://www.dwl.de/index.php?Himmel%20Diagnose. Copyright 2013 Compumedics Germany.

The apnea test is the final test that confirms if a physician will remove the ventilator. The brain's most primitive function is to breath and therefore if the patient fails to gasp for air once the ventilator is removed, the patient is pronounced brain dead. At that time, the physician will place the patient back on the ventilator not to support the patient's life, because they are legally dead, but to continue the oxygenation of the organs for procurement.

Each year there are over 8000 donations after brain death, with each individual saving as many as 8 lives.[62] These donors may also contribute to composite grafts for limbs and faces.[63] As some scholars note, "transplantation is 'a victim of its own success', with improvement in the lives of recipients, the demand for transplants has far outstripped the supply." [64] While, brain death donors make the ideal candidates, namely, organs are maintained at an optimal condition for donating, there are a number of patients who present devastating brain injuries but are not brain dead.

B. Donation After Cardiac Death

Some patients may present with severe brain injury with a poor prognosis but may not meet the criteria for brain death. This is the second group of Life Support Withdrawal Donors referred to as donation after cardiac death.[65] These are patients who die under the traditional definition of a cessation of circulatory and respiratory function. In order words, once the family decides to remove life support, the heart stops and the physician declares death.[66] These are patients in critical care who may be in a temporary coma or progressive into a vegetative state. A person in a coma for example, does not open their eyes or speak and is in a state of unresponsiveness resulting from severe illness or brain injury.[67] They may or may not need ventilators and remain in this state generally from a few days to a few weeks.[68] This is a temporary state where the

[62] BIOETHICS, *Supra* n. 40
[63] Organ Procurement and Transplantation Network. Donor: donation after circulatory death (DCD) by donation year. Donors recovered: January 1, 1988-March 31, 2018. https://optn.transplant.hrsa .gov/data/view-data-reports/build-advanced/. June 1, 2018.
[64] Mark D. Fox, Stewards of a Public Trust: Responsible Transplantation, 3 AM. J. BIOETHICS v, vi (2003).
[65] BIOETHICS, *Supra* n. 40
[66] BIOETHICS, *Supra* n. 40
[67] BIOETHICS, *Supra* n. 40
[68] Id.

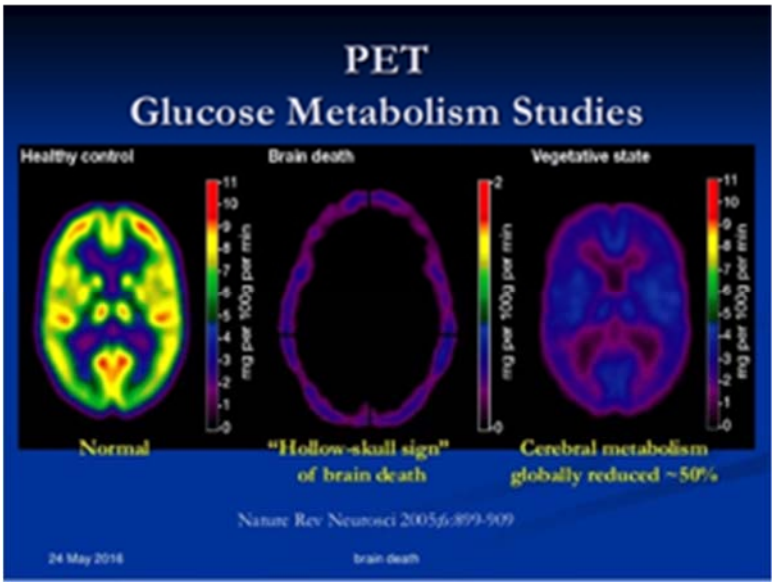
patient may gain consciousness, progress to a vegetative state, or die.[69] The family may act on behalf on their belief of their loved one's best wishes to withdrawal life support if there are no signs of recovery. There may also be advance directive in place which governs the withdrawal or continuation of life-sustaining treatment.

By contrast, a patient in a vegetative state has a depressed consciousness and brain stem function.[70] They can breathe without support and respond to pain, sounds, and go through sleep-wake cycles.[71] If a person continues in this state for more than a year they are considered to be in a persistent vegetative state with almost no chance of recovery.[72] Patients in this state were the motivating factors in the right-to-die case law that emerged following highly publicized cases of patients maintained by artificial means despite their family's wishes. The creator of the term, "persistent vegetative state", Dr. Fred Plum described it as the following:

> Vegetative state describes a body that is functioning by its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

In re Jobes, 108 N.J. 394, 403, 529 A.2d 434, 438 (1987).

[69] Id.
[70] Id.
[71] Id.
[72] BIOETHICS, *Supra* n. 40



Donations after cardiac death ideally could increase organ donations by up to 30%, but its limitations, namely by the Dead Donor Rule, ensure that increase is never met. This is because under the donations after cardiac death, a physician is charged with the difficulty of determining the exact death of a patient before procurement can take place. Otherwise, a physician would violate the Dead Donor Rule and could potentially face liability.

The following is the procedure for donations after cardiac death for a patient who presents with severe brain damage who do not meet the criteria for brain death and are therefore, still alive but maintained through artificial life support. First, a physician will inform the family of the prognosis, approach the family on their options to remove life support. If the family consents, the next the next step would be a consultation on organ donation. This involves many moving parts and players including a social workers and attorneys. UNOS will be notified once it is determined that the patient is an organ donor and they will facilitate that conversation with the help of a social worker and the physician. The patient would be taken to an operating room where

the breathing tube would be removed and it is at this time the family says their goodbyes.[73] Once, the patient's breathing stops and the heart gradually slows into an eventual stop. The patient will then be transported to another operating room, prepped for surgery, and observed by the physician for any signs of a returning heartbeat. If there are no changes in her heartbeat in those five minutes, the patient has suffered an irreversible cessation of the circulatory and respiratory system and therefore can be declared legally dead. Only after this declaration can a surgical team make their first incision and begin removing organs. The issue arises in cases of patients whose hearts continue to pump gradually after the withdrawal of life support. The organs face potential ischemic damage while physicians, abiding by the Dead Donor Rule, must wait to first declare the patient dead.

V. Analysis:

A. The Dead Donor Rule Eliminates Countless Organs from the Donation Process

Currently, the Dead Donor Rule requires that a patient die before they can donate. This presents limitations on donations after cardiac death. The most obvious is that heart transplantation is no longer possible. There is also a concern that organs may no longer be viable in the time needed to wait for the heart to stop.[74] That window between when the heart stops and when organs are retrieved is critical because the organs can only last so long without blood and oxygen.[75] For example, the liver can only be retrieved within 30 minutes while the kidney and pancreas are viable for up to one hour following the withdrawal of life support.[76]

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[73] *When does Death Start?* The New York Times Magazine (December 16, 2009); https://www.nytimes.com/2009/12/20/magazine/20organ-t.html (Embracing a new way of dying through organ donation).
[74] Id.
[75] Id.
[76] BIOETHICS, *Supra*, n. 40

Robert Truog, who writes extensively on the future of organ donation, with a focus on the Dead Donor Rule, described the concern of losing organs during non-heart beating donations.[77] In one case, the Dead Donor Rule prevented the parents of a young girl from donating after an accident left her with severe brain damage.[78] The first loss, hearing that their daughter would never recover was devastating, but they found in solace in the opportunity to donate her organs.[79] When her heart did not stop in time to procure viable organs, her parents experienced as second loss in missing the chance to make an end-of life donation to honor their daughter.[80] This happens often and presents a reasonable challenge to strict adherence to the Dead Donor Rule.

The following statistics show the number of organs lost due to ischemia damage. 3,631 kidneys and 739 livers were lost in 2016 while waiting for the heart to stop. The 2014 paper in the American Journal of Bioethics estimated that waiting for cardiac arrest after removal of life support, and then waiting a few minutes more, eliminates 2,200 organs from the donor pool each year. Another 6,700 organs may be lost annually while waiting for donors with severe brain injuries to progress to brain death.[81] Allowing patients near death to donate prior to death, would greatly increase the supply of viable organs.

B. <u>There are Potential Sources for Organ Donation by the Imminently Dying</u>

There are a number of patients facing imminent death that are not yet on life support. The focus is on both living donors who have decision-making capacity and a carved out exception for anencephalic newborns who never had decision-making capacity, but whose parents consent to

[77] R. D. Truog, F. G. Miller, and S. D. Halpern, *The Dead-Donor Rule and the Future of Organ Donation*, THE NEW ENGLAND JOURNAL OF MEDICINE 1287 (2013).
[78] Id.
[79] Id.
[80] Id.
[81] Id.

organ donation. This would mean that instead of allowing their impending cause of death to take place naturally, the organ donation would be the cause of death. This necessarily calls for an abandonment of the Dead Donor Rule and consequently a reevaluation of the other ethical principles of medical ethics that guide the transplantation system.

In challenging these ethical principles, many patients will be afforded the option to breathe meaning in their death by donating life-saving organs. To be clear, this suggests that a patient who has already decided to either withdraw life support (the pool of donors otherwise known as donations after cardiac death) or hasten their impending death from terminal or degenerative disease (donations by the imminently dying) would instead be kept alive up and until the point of organ donation. This would bypass the issues raised with donations after cardiac death which yield suboptimal organs and exclude heart transplants. This also makes it increasing hard to transplant lungs because of the dependency on the heart. In other words, it would be the act of donating that would kill them. The argument here is to challenge the view that donating is the thing that kills and instead hold that the patient is already dying because there is no reversibility to the withdraw or treatment or aid in dying and therefore, organ donation would merely hasten an inevitable death.

i. A Utilitarian Approach: Maximizing the Number of Organ Donations

Utilitarianism is type of moral theory emerging from the broader concept of consequentialism. Consequentialism distinguishes between right and wrong by looking at the overall consequences of one's actions.[82] This would include spreading happiness and reliving suffering, creating as much freedom as possible, or promoting the survival of humans. The principle of maximum utility holds that the moral act is one that promotes the greatest

[82] Walter, Sinnott-Armstrong, *Consequentialism,* The Stanford Encyclopedia of Philosophy.

consequences for the greatest number.[83] This is commonly referred to as the "Greatest Happiness Principle", achieving happiness for the most amount of people. Under this theory, the interest of others, as a whole is taken into account above one's own interests.[84] A general application of this principle would yield positive results for increasing organ donations where a simple solution is to generate the most organs to promote health and therefore happiness of the most people. Yet, other ethical principles cut against the reliance on a utilitarian approach.

This article proposes procuring more organs by looking to new sources for donations such as living donors. Critics of utilitarianism would argue that doing so would contradict other ethical principles. However, those principles should not implicate the need to generate more organs when the donors are already facing death and choose to end their lives by donating their organs.

ii. The Dead Donor Rule Should Only Apply Non-Maleficence

First, the Dead Donor Rule explicitly prohibits the killing of patients to obtain their organs.[85] For donations under cardiac arrest, the physician is withdrawing life support, which ultimately leads to a patient's death. Yet, in the eyes of the law, there is a clear distinction between a physician who withdraws life support and therefore allows a patient's heart to stop and a physician who administers a lethal injection to a patient.[86] The former applies to the physician letting a patient die, which as explained in cases of donations after cardiac death, is not a violation of the Dead Donor Rule. In these 'right to die' cases, as they are commonly referred to, the courts were persuaded by a competent patient's right to die stemming from the common law principle of

[83] Aparna R. Dala, *Philosophy of Organ Donation: Review of Ethical Facets,* World Journal of Transplantation, 44, 45 (2015).
[84] *Utilitarian Theories,* Online Guide to Ethics and Moral Philosophy, (1996).
[85] Robertson JA. *The Dead Donor Rule.* Hastings Cent Rep. (1999) 6,8; Joffe A. *The Ethics of Donation and Transplantation: Are Definitions of Death Being Distorted for Organ Transplantation?* Philos Ethics Humanit Med., 28, 30 (2007).
[86] See Right to Die Cases in Fn. 87-88.

self-determination and informed consent.[87] The latter, on the other hand, applies to the greatly opposed act of euthanasia. In those cases, courts drawn a distinction between patients on life support and those who are terminally ill or imminently dying.[88]

The Dead Donor Rule intended to prohibit the killing of a patient in order to obtain their organs. Still, in donations following the withdrawal of life support a physician's action causes the death of the patient, but we do not view this the same as killing a patient. Instead, withdrawing life-sustaining treatment is seen as an act of letting die rather than killing. This is the important distinction that makes it possible for there to be a widespread prohibition on euthanasia but acceptance with discontinuing life support.[89]

iii. "Do No Harm" Should Not Mean Keeping Someone Alive Indefinitely

The principle of 'primum non noncore' or "First, do no harm" guides the medical practice.[90] It is embodied in the Hippocratic oath for physicians and stands as the direct support for the Dead Donor Rule. However, this is a relative concept since harm is subjective to a patient and depends wholly on informed consent. Some harms are permissible with the consent of a

[87] *Cruzan v. Director*, Mo. Dept of Health, 497U.S. 261 (1990): requiring "clear and convincing evidence" of a patient's wishes for the removal of life support; *Vacco v. Quill*, 521 US 793 (1997): holding that states have legitimate interests in preventing doctors from assisting their patients to die, even those who are terminally ill or in great pain; *In re Quinlan*, 355 A.2d 647 (N.J. 1976): finding the removal of "extraordinary means of treatment," namely a ventilator, would not constitute the form of homicide known as euthanasia. Because the patient's father, seeking a protective order for the removal of a ventilator from his daughter was Roman Catholic, the New Jersey Supreme Court quoted extensively from an address by Pope Pius XII regarding the principle of double effect in the withdrawal of extraordinary means of life-sustaining treatment.

[88] *Washington v. Glucksberg*, 521 US 702 (1997): holding physician-assisted suicide is not protected by the Due Process Clause; *Gonzales v. Oregon*, 546 US 243 (2006): holding U.S. Attorney General could not enforce the federal Controlled Substances Act against Oregon physicians who prescribed drugs for the assisted suicide of the terminally ill in accord with Oregon law.

[89] Ben Bronner, *Two Ways to Kill a Patient,* Journal of Medicine and Philosophy, 44,44 (2018).

[90] World Journal of Transplantation, *Supra* n. 83

patient. For example, a patient who consents to living donation is harmed by a physician. Donors may experience pain following the surgery, short-term disability, and possible complications. A living donor surgery has a 5% to 10% risk and the risk of death is 0.5% to 1%.[91] For patients for whom is is permissible to withdraw life support, death cannot be considered a harm since they have already consented to the act that would cause their death.[92]

Further, this principle of non-maleficence prohibits intentional harm to patients. In the case of organ donation, donors consented to the harm. The imminently dying are arguably suffering more harm living and progressing into greater harm than if they were allowed to die in the manner and time of their choosing. For example, a patient who is suffering from a degenerative neurological disease that will necessarily kill her, faces no additional harm if she chooses to die sooner. Physician-assisted death applies to the competent patient who suffers from a terminal illness with a prognosis of six months of less to live.[93] Physician-assisted death is legal is eight U.S. states by law, including New Jersey where courts have halted its effect.[94] In two other states, the courts have legalized physician-assisted suicide.[95]

iv. Personal and Bodily Autonomy Gives Individuals the Right to Donate

Personal and bodily autonomy is the freedom of a person to do what they wish with their body. Autonomy includes consent, choice, independence, and self determination. Physician assisted death rest on the autonomy of the individual to choose to end their life with dignity.

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[91] Id.
[92] Bioethics, *Supra* n. 66
[93] Id.
[94] Colorado, District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont, Washington; New Jersey Governor Phil Murphy signed the Aid in Dying law for the terminally ill in April 2019 but was temporarily halted by two court decisions. Ultimately, the appellate judge reversed the superior court's holding.
[95] Montana and California.

The importance of autonomy can be best explained in the context of a real-life person facing a terminal illness [96]:

> I have lived a good and a long life, and have no wish to leave this world prematurely. As death approaches from my disease, however, if my suffering becomes unbearable I want the legal option of being able to die in a peaceful and dignified manner by consuming medication prescribed by my doctor for that purpose. Because it will be my suffering, my life, and my death that will be involved, I seek the right and responsibility to make that critical choice for myself if circumstances lead me to do so. I feel strongly that this intensely personal and private decision should be left to me and my conscience—based on my most deeply held values and beliefs, and after consulting with my family and doctor—and that the government should not have the right to prohibit this choice by criminalizing the aid in dying procedure.

Robert Baxter, Supplemental Affidavit, Baxter v. Montana, June 28, 2008.

i. Anencephalic Newborns

Another patient group eligible for IDD would be anencephalic newborns, who are born without a cerebral cortex who never gain consciousness.[97] This condition always leads to death though the timing varies. A limited exception, should allow the parents of anencephalic newborns to donate their organs. The babies are in a distinct category than other donors because they were never conscious. Compared with the patients who were once conscious and who have the autonomy to make an informed decision regarding their lives.

In a Florida Supreme Court case, the mother of an anencephalic newborn carried her baby to term with hopes of donating its organs upon birth.[98] However, the President's Commission stated that this would violate the UDDA which disallowed equating anencephaly with death.[99] The Florida court likewise held:

[96] The concept of autonomy and dignity that drives the support for physician assisted death laws.
[97] In re T.A.C.P. No. 79582. November 12, 1992. Supreme Court of Florida.
[98] Id.
[99] Id.

> We find no basis to expand the common law to equate anencephaly with death. We acknowledge the possibility that some infants' lives might be saved by using organs from anencephalic patients who do not meet the traditional definition of "death" we reaffirm today. But weighed against this is the utter lack of consensus, and the questions about the overall utility of such organ donations. The scales clearly tip in favor of not extending the common law in this instance.
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> In re T.A.C.P. No. 79582. November 12, 1992. Supreme Court of Florida

In doing so, the court recognized a "whole brain death" and refused to recognize anencephaly as brain death to facilitate organ donation.[100] However, this carved out exception should apply so long as the parents consent to the donation. This brings about concerns regarding the value of life of this population but the argument should still stand, that because these babies do not feel harm and their death is imminent, it would serve to promote a greater benefit to donate their organs.

ii. Organ Donations by Prisoners on Death Row

Execution of prisoners on death row is commonly done by the injection of a three-drug combination used to induce unconsciousness, cause muscle paralysis, followed by respiratory arrest, and ultimately cardiac arrest.[101] If they were able to donate this place them in the category of donation after cardiac death. However, under medical standards and assuming medical screens have been performed, they are suitable candidates for imminent death donations, which would include the heart. The procedure would need to change to allow the prisoner condemned to death to be put in a medically-induced coma, such that the taking of the heart would ultimately end the prisoner's life. Because the prisoner faced death anyway this would not bring harm to the patient who would otherwise have died anyway. There is concern that offering the prisoner the option to donate their organs rather than receiving a lethal injection can be seen as coercion. On the one hand, because the prisoners are on death row there is no opportunity for coercion that can come

[100] Id.
[101] Shu S. Lin et Al, *Death Row Prisoners as Organ Donors*, Ethics in Cardiothoracic Surgery, 1773, 1775, (2011).

from exchanging an organ for a shorter prison sentence. On the other hand, prisoners might feel pressure to donate in order to end their lives on a positive way.[102] This hardly seems like coercion given that prisoners have the right to not donate.

C. Conclusion

It has been over fifty years since the medical community introduced brain death through the Harvard Committee Report, motivated by the staggering statistics of organ donations and the need to facilitate this system. Today, the numbers are even more overwhelming. As one Harvard Committee member questioned, "Can society afford to discard the tissues and organs of the hopelessly unconscious patient when they could be used to restore the otherwise hopelessly ill, but still salvageable individual?"[103] In eliminating the Dead Donor Rule, a number of potential sources for organ donation will be possible. This country values autonomy and informed consent and is slowly moving towards effectuating those principles through physician assisted death laws. If we already allow patients to end their lives through the withdrawal of treatment or life-ending prescription drugs, then allowing them to donate their organs for a greater cause should be acceptable.

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[102] See Susan M. Behuniak, *Death with "Dignity": The Wedge that Divides the Disability Rights Movement from the Right to Die Movement,* Politics and the Life Sciences, 17, 25 (2011). Disabled individuals are grouped with the terminally ill. This can lead to disabled individuals feeling pressure to donate in order to save a non disabled individual which presents challenges in placing values on the quality of life.