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Ethics & Bioethics (in Central Europe), 2018, 8 (3–4), 189–200 DOI:10.2478/ebce-2018-0014

The ethical problems of death pronouncement and organ donation: A commentary on Peter Singer's article

Ireneusz Ziemiński[1]

Abstract

The article is a critical commentary on Peter Singer's thesis that the brain death definition should be replaced by a rule outlining the conditions permitting organ harvesting from patients who are biologically alive but are no longer persons. Largely agreeing with the position, I believe it can be justified not only on the basis of utilitarian arguments, but also those based on Kantian ethics and Christianity. However, due to the lack of reliable methods diagnosing complete and irreversible loss of consciousness, we should refrain from implementing upper brain death into medical practice. Organs also should not be harvested from people in a persistent vegetative state or from anencephalic children, for similar reasons. At the same time, patients who suffered from whole-brain death should not be artificially sustained; in light of current knowledge they can be declared dead and become organ donors.

Keywords: brain death, person, organism, donation, transplantation, Peter Singer

Introductory remarks

The irreversible end of brain functions is a criterion for human death in most countries nowadays, however it turns out to no longer be sufficient due to the advancement of medicine – it is now possible to keep people alive even if their brain is completely damaged (Lizza, 2018b, p. 86). It shows that complete brain damage does not necessarily result in the death of the entire organism as an integrated entity (Singer, 2018, pp. 156, 162), because many biological functions can be artificially replaced. A person connected to a respirator, fed with a feeding tube can continue to live as a biological organism capable of digestion, fighting infections, or maintaining temperature, even after the loss of all brain functions. For example, a patient who was declared brain dead at the age of four but is connected to a respirator and artificially fed, remained alive for over fourteen years (Singer, 2018, p. 156). This raises the question of whether one can be disconnected from a respirator and have their organs retrieved for transplants just because their brain is dead. Singer's article is an attempt to answer this question. In the first part of the commentary I will limit myself to presenting Singer's position (which I largely agree with) and adduce a few arguments which could justify it but have been omitted by him. In the second part I will sketch out the difficulties of putting Singer's propositions into practice.

Part I: Singer's position and its justification

Singer defines human death as the death of the upper brain (Singer, 2018, p. 162), because it is one's personal life consisting of conscious actions rather than biological functions, that is the essence of human existence. Therefore, if the death of cerebral hemispheres results in an irreversible end of consciousness (Singer, 2018, p. 164) it should be considered human death regardless of the body's continued life (Singer, 2018, p. 164).[2] This solution should contribute to the advancement of transplantation medicine; if the death of a person is different from the death of the body and can happen independently of its continued life, then it is allowed to retrieve

[1] University of Szczecin (Poland); email: Ireneusz.Zieminski@usz.edu.pl

[2] Other authors such as Jeff McMahan (McMahan, 1995, pp. 91–126; McMahan, 2006, pp. 44–48) or John P. Lizza suggest similar solutions (Lizza, 2018a, p. 13).

organs not only from biologically dead people, but also from those who are alive but have permanently lost consciousness (Singer, 2018, p. 164). This conclusion suggests that Singer's goal was not necessarily to formulate a new criterion of death, but rather settling whether a living person can become an organ donor (Singer, 2018, pp. 160–161).[3] The answer is simple: the end of upper brain function resulting in irreversible loss of consciousness is a necessary and sufficient condition of a patient becoming an organ donor (Singer, 2018, p. 164).

The lack of any (at least subjective) value to the life of the potential donor, who does not have any conscious experiences after the death of their upper brain, serves as justification; after all they are not even aware that their body is alive. Meanwhile life is only valuable to us as long as it is conscious, the possibility of which needs to be excluded in the case of upper brain death. Thus, since the person will never know about it, harvesting their organs does not harm them.

Further justification for cerebral death is linked to the development of transplantation medicine. According to Singer, this was also the reason behind replacing the cardiopulmonary criterion of death with the whole-brain criterion, formulated in 1968 by the Harvard Brain Death Committee. The new definition of death was not a result of new scientific discovery, but rather the desire to help those patients who could be saved by transplants; in reality it determined the conditions of harvesting organs from potential donors (Singer, 2018, p. 155). Although the Harvard Committee only allowed for retrieving organs from the dead while Singer believes that those who remain biologically alive can also become donors, in both instances the issue is to not artificially keep people alive if they are irreversibly deprived of consciousness, especially if their organs could save other people (Singer, 2018, pp. 161–162).

At first glance, replacing the definition of death with a rule regulating the circumstances of becoming an organ donor seems unacceptable; after all, whether a person died has nothing to do with the value of their life or the needs of other people. Therefore, the issue of defining death should be determined on the grounds of science (biology and medicine) and not axiology (morality). The definition of death should not be dependent on evaluating life, but rather on what life is and when it ends. Positioning the argument within an axiological framework leads to the question of who is allowed to determine the value of a patient's life and whether consciousness is a determining factor in this evaluation. After all, one cannot exclude the possibility that someone suffering from terrible pain or experiencing loneliness after losing their loved ones would want to become unaware of their state; a conscious life is not always more valuable than an unconscious one. While consciousness is a key factor in the prohibition on inflicting pain, we have the right to live because we were born, not because we are conscious; even permanent loss of consciousness does not mean losing the right to live.

Making death pronouncements dependent on other people's needs is equally difficult. Even if the organ recipients are conscious while the donors have irreversibly lost it, they are both alive in a biological sense. Therefore, if an organ transplant is performed, someone is killed to save another which undermines the universality of the human right to live.

These counterarguments do not, however, refute Singers position; on the contrary, they confirm his belief that classifying someone as an organ donor is not a matter of science but ethics. Both proponents and opponents of harvesting organs from living donors agree with this thesis; the first group care about those whose conscious lives can be extended without harming others, while the second group is concerned with taking away the right to live from innocent people (even if they are permanently deprived of consciousness) for the sake of transplants.

[3] Other authors hold similar views; Norman Fost believes that there is no need to change the definition of death in order to save transplantation medicine, it is enough to change the rules of organ donation (Lizza, 2018b, p. 87).

Therefore, the argument is fought on the grounds of ethics and not medicine; it is not about whether the potential donor is dead, but whether a specific action (performing a transplant or not) will harm someone (the donor or the recipient).

The definition of death is not a purely empirical problem, it is also an axiological one because its content is dependent on what we determine to be true human life. The pursuit of a universal definition of death which would apply to all living creatures is itself destined to fail; even brain death is not a universal criterion since there are organisms who do not have brains and yet are born and die (Singer, 2018, p. 162). Therefore, there is no one, universal concept of death (Lizza, 2018b, p. 81), the death of each individual depends on what type of being they are (Lizza, 2018a, p. 14). It is equally difficult to offer a definition which would apply to all people and only to people; e.g. in the case of upper brain death anencephalic children, who are born without cerebral hemispheres, pose a problem.

Another obstacle in defining and declaring death is its processuality which makes it harder to point to a specific event which turns a living person into a dead one. While it is obvious that if all of somebody's cells died then they too are dead, but it would also be a mistake to wait until the last cell dies in order to declare somebody dead. Searching for a specific event that makes the process of dying irreversible is equally problematic because it is not clear that such an event exists. Even the irreversibility of the process of dying is questionable and depends on the situation; a patient experiencing a massive heart attack can be saved if they immediately receive medical attention. On the other hand, even a minor cut in the jungle, without access to medical help, can result in death. A physician deciding whether to continue treatment or let the patient die is a similar situation, each decision like this is based not only on medical data but also moral beliefs. This suggests that a death pronouncement can be as arbitrary as declaring someone to be an adult because it is affected by various factors (including an understanding of the value of life).

One should also keep in mind that in some cases the cost of saving one person is the death of another, otherwise they both die. Therefore, giving up on transplants because of the universal right to live is just as morally suspect as taking one person's life to save another; however, a decision must be made. Moreover, it is obvious that medical practice does distinguish people on the grounds of the value of their lives. The reasons behind treating one person and not treating another are not only medical (predicted success of treatment) but also social – linked to the person's prestige and their importance to the community. Those who govern (and make strategic decisions), soldiers (who defend the borders), or doctors (who save lives) are a priority when it comes to treatment, which shows that the lives of some people are considered more valuable than the lives of others.

Anthropological factors connected to how we understand human nature are another important factor in death pronouncement or agreement to harvest one's organs (Lizza, 2018a, pp. 5, 14). Singer refers to dualistic concepts of human existence by distinguishing between one's organism (biological life) and person (consciousness). Consciousness is significantly more important and its irreversible loss (regardless of the organism's continued life) allows for declaring a person dead and harvesting their organs (Singer, 2018, p. 157). However, as long as a person has consciousness, they cannot be declared dead, even in the case of complete bodily dysfunction. This means that actual death is the death of the person and not the body (Singer, 2018, p. 162). However, this solution is problematic given the existence of anencephalic children who are born without cerebral hemispheres. By adhering to Singers assumptions, one would have to claim that these children are not, never were, and never will be persons and so they fulfill the criteria to become organ donors.

The dualism of organism and person suggests that the body is not an integral element of a human being; it is only important as a foundation or tool of consciousness. However, the moment consciousness is irreversibly dead, the biological organism ceases to be human. Therefore, if it were possible to separate the upper brain (which is the physical foundation of consciousness) from the rest of the body and keep it alive, then one would have to conclude that the person is still alive. Conversely, the body is an integral element of a human being and without it one is not fully human; therefore, as long as the biological organism is alive, one should not be declared dead. A person ceases to live neither when they irreversibly lose consciousness (while their organism remains alive), nor when they remain conscious (thanks to artificially maintained bodily functions); they are dead after both the death of the body and the person.

Even if one does assume that this argument is correct, it should be acknowledged that it does not refute Singer's position because dualism (which highlights the role of consciousness) is a more accurate description of a human being than animalism (which equates them with a living organism). It is confirmed by the fact that we are more likely to assign more human impulses to a person who remains conscious despite a completely dysfunctional body than to one in a permanent vegetative state. For example, one could consider a thought experiment concerning the possibility of a head transplant. If such surgery could indeed be performed[4] then one would have to assume that the person whose head was attached to a different body is the one still alive rather than the one whose body was preserved. Similarly, if it were possible to detach a head from a body and keep both of them alive, we would be more likely to identify the person as the head rather than the body (Lizza, 2018b, pp. 83–84) because consciousness is generated by the brain which is inside of the head. If a headless body which is artificially kept alive is not a human then it would follow that a body is no longer human after the death of the upper brain, despite being connected to a respirator and artificially fed (Lizza, 2018b, pp. 73–74).

This conclusion (which resembles Singer's beliefs) does not solve the issue of consent to harvest organs from people irreversibly deprived of consciousness. The main problem is posed by anencephalic children who are clearly alive even though, to best of out knowledge, they do not have any conscious experiences; thus, they are not persons but organisms (Singer 2018, p.162). If they are not conscious, then according to Singer's assumptions, shortening their life in order to harvest their organs does not cause them harm. However, one could assume that such an action would be deemed morally suspect at least on the grounds that if these children were never persons, they could not have consented to the donation. Therefore, their case is different from that of people in a permanent vegetative state, who at least were persons in the past and could have consented. Moreover, lack of consciousness alone is not a sufficient argument to deprive anyone from their right to continued life (even if it is only biological).

Another issue is the diagnosis of permanent lack of consciousness itself, both due to insufficient machinery which could confirm its complete and irreversible loss, as well as the difficulty with formulating an unequivocal definition; consciousness is subjective (private) and gradable (Nguyen, 2018, pp. 56–57). There is anecdotal evidence of a patient who was declared brain dead and yet could hear what was being said around them, however they were unable to react (Nguyen, 2018, p. 57). Therefore, one cannot be certain that currently available medical procedures guarantee foolproof diagnoses which means that legalizing the definition on death proposed by Singer would be too risky. It does not mean that upper brain death is a bad criterion for death, but it should not be utilized due to lack of reliable methods for diagnosing it. Death

[4] Experiments like this were already performed on monkeys (Lizza, 2018b, p. 73).

pronouncement and organ donation require the highest levels of caution, minimalizing the risk of mistakes.

Besides ethical and anthropological justifications, Singer's argumentation also uses cultural justifications. There is no doubt that the dilemmas surrounding death pronouncement and donation are settled in a broader religious, moral, and social context in which the doctors and patients function. After all, science (including medicine) is not axiologically or ideologically neutral (Lizza, 2018a, p. 4); the formulation of medical laws is influenced by superstitions, myths, and social customs. Moreover, one should keep in mind that legal regulations often come later than medical practice and only sanction it ex post. For example, in Poland the brain criterion is the standard for death pronouncement, however, the cardiopulmonary criterion is allowed in transplant practice; this means that it is possible to harvest organs from donors who are legally alive (Nowak, 2018a, p. 38). Similar practice is present in the United Kingdom, where almost half of all harvested organs in 2016 came from donors who were declared dead based on the cardiopulmonary criterion (Nowak, 2018a, p. 36). The argument in favor of this practice is the assumption that cardiopulmonary death inevitably leads to brain death ; it is conceivable that the operative observation period of five minutes is too short to ensure that the organs were retrieved from a dead person (Nowak, 2018a, p. 40; Nowak, 2018b, p. 66). However, if this is in fact medical practice, then it is all the more reason to consider revising the criterion for death. It is hard to conceive that an increasing number of people irreversibly deprived of consciousness will be kept alive using up resources which could be devoted to treating those patients who are conscious of their state and who can recover. It is a problem that concerns everybody because everyone can become either an organ donor or recipient. Perhaps this is why Singer is an optimist and believes that most people, if they have knowledge about transplant medicine, will consent to their organs being used to save others (Singer, 2018, p. 161). Consent can be expressed in a declaration of will signed while one is conscious and can make decisions about their future (Singer, 2018, p. 163).

Contrary to Singer's optimism, convincing people to consent to the donation may be difficult, not necessarily due to bad will, egoism, or excessive attachment to life, but rather fear that a declaration of will result in a patient being declared an organ donor even in a situation when treatment could be continued. This fear should not be treated lightly, especially since there have been cases which could justify it – for example events that took place years ago in Łódź, a Polish city. There was a group of employees in an emergency room who injected patients with deadly poison and proceeded to inform a funeral business about the deaths. The company then contacted the family of the deceased and offered their services (Kołakowska, Patora & Stelmasiak, 2000). If it was possible that patients were killed for financial gain then it is conceivable that they could also be killed for their organs.[5] Therefore, legal regulations require caution regarding organ retrieval from living people. Avoiding abuses is not conditioned upon social debate about transplants or declarations of will but rather on restrictive legal and medical procedures of donation. While there are plenty of people prepared to give up their lives to save others, there are also those who will not be reluctant to benefit from the deaths of others.

Regardless of possible abuses, a declaration of will is also problematic on other grounds. It is a form of social contract (one agrees to the harvesting of their organs trusting that others will do the

[5] An equally drastic, albeit fictional, situation was described by Roman Bratny in the novel *Radość nagrobków* [Tombstone Joy] (Bratny, 1978). One of the characters is a physician who loves to give eulogies and so he kills his patients to create more opportunities for his rhetorical displays. One cannot exclude the possibility of similar actions in real life, after all history shows that people are capable of anything.

same), however it is difficult to execute. If someone does not consent to organ donation and wishes to be kept alive even after the death of their upper brain, then the medical system becomes reliant on the will of the patients, which goes against the rule of everyone being equal under the law; those who consent to becoming organ donors will not be kept alive, while those who do not give such consent will be treated. To avoid this inequality, individual declarations of will should be replaced by a law which would affect everyone.

The problems with implementing Singer's proposal do not undermine the fact that it is fundamentally right; it should be possible to harvest organs from people who are irreversibly deprived of consciousness, in order to save the lives of others. In some cases, we not only have the right, but even an obligation to kill innocent people to save other, equally innocent, people. If there is a plane with two hundred people on board flying in the direction of a hotel with a thousand people, everyone who can, should shoot it down. Although passengers will die as a result, the hotel guests will be saved; if one takes no action, both the passengers and the guests will die. Medicine is similar, if some people can be saved by harvesting organs from those who will never regain consciousness, then this is the appropriate course of action, otherwise everyone will die.[6]

However, this seemingly simple solution can turn out to be dangerous; if permanent loss of consciousness (caused by upper brain death) is to be the condition for organ harvesting then those whose brain stems (lower brain) are intact and are capable of breathing on their own, could be considered organ donors. In these cases, donation would not be the result of death caused by other factors, but the cause of death; the patient will stop living only because their organs were needed to save other people. This would lead to a radical instrumentalization of humans as organ banks and to violation of the right to live. Singer himself sees this problem and admits that the donor rule he proposes goes against both Kantian ethics of human dignity and Christian ethics of equality of all people.

References to Kantian ethics which prohibits using a human solely as means to an end, can be found in a report by the President's Council on Bioethics from 2008, which excludes the option of treating patients as organ donors (Singer, 2018, pp. 158–159). According to Singer the reference is a mistake because transplant medicine is based on utilitarian arguments (Singer, 2018, p. 160); the categorical imperative can only be applied as an addition and only if its content is extended (Singer, 2018, p. 160). It would have to be acknowledged that the prohibition on treating a person as means to an end only applies to actions against their will; if, however, the person voluntarily agreed to become a donor, then their organs can be harvested (Singer, 2018, pp. 160–161). In these circumstances they are not being treated instrumentally; they freely expressed how they wish to be treated in case of irreversible loss of consciousness.

One could also argue that even a donor who did not consent is not treated completely instrumentally by transplant medicine. In a society which allowed organ donation after upper brain death everyone would be a potential organ donor and recipient. Therefore, everyone would be both the means and the end, which is compatible with Kantian ethics prohibiting only those actions in which a person is just the means and not the end.

The donor rule proposed by Singer is also compatible with another formulation of the Kantian imperative which warrants actions in accordance with the rule we would like to become universal. Therefore, if I consent to the harvesting of my organs after my upper brain dies, I want others to give similar consent. If I am against such actions, it means I also do not want others to

[6] A total prohibition on abortion, as advocated for by radicals, is a similar issue; in a case when the pregnancy is a direct treats to the live of the mother a ban on abortion results in the death of the mother and the child.

consent to becoming organ donors. Thus, I seal my fate not only as a potential donor, but also as a potential beneficiary of transplant medicine.

Singer's view can also be justified as compatible with Kantian ethics by arguing that those who suffered brain death and irreversibly lost consciousness are no longer persons. If reason and freedom are essential to a person, then purely biological organisms without a mental life are not persons; therefore, the Kantian imperative does not apply to them. It should be noted, however, that the prohibition on instrumental treatment of people can be used in other cases important to medical ethics. While considering a person after upper brain death as purely an organ donor is unacceptable (it would mean using them as just means to an end), it is acceptable to put an end to someone's suffering through death and at the same time harvest their organs; in this scenario, the person is not just the means, but also the end. These examples show (contrary to Singer's suggestion) that Kantian ethics can solve the dilemmas surrounding death pronouncement and transplants (Singer, 2018, p. 160).

Singer also notes the incompatibility of his proposal with the Christian principle of equality of life (Singer, 2018, p. 163). If the life of every human (including those who are no longer persons) is equally valuable and falls under the same legal protections, then harvesting organs from people who suffered upper brain death is out of the question. It would seem that in order for transplant medicine to continue developing one has to reject the Christian sanctity of life ethic which prohibits the intentional killing of an innocent human being (Singer, 2018, p. 163).

This opinion is too pessimistic, because the revision of rules for donation proposed by Singer can be made compatible with Christian ethics. First of all, it should be noted that the evangelical concept of life is not about maintaining biological functions but rather spiritual unity with God. Therefore, artificially maintained bodily functions is not true human life, but spiritual adoration of the Creator certainly is; as Jesus taught, one should not fear those who kill the body, but those who can kill the soul (Mt 10, 28).[7] If earthly life is not the highest value but only a preface to the afterlife then there is no reason to sacrifice it because of the greater good. It would suggest that due to eschatological hopes a Christian would be more likely to consent to ending treatment and harvesting their organs then someone who does not believe in eternal life.

The philosophical interpretation of Christianity expressed by Thomas Aquinas is also close in spirit to Singer's dualism. He assumed that the soul is the source of personal life and it makes acts of intellect and will possible. However, when the body is damaged, the soul can no longer function (STh, I, 1 75–76). While it is not equivalent to death (which according to Aquinas meant the separation of body and soul), we do observe a lack of personal life; this conclusion is compatible with Singer's thesis that people whose upper brain was damaged are no longer persons. Since personal life, from a Christian perspective, is better than non-personal life, one should save the patient whose soul can express itself through a body rather than the one whose soul is no longer capable of actions (due to brain damage).

One should also keep in mind that Christian ethics teach mercy for those who are suffering; in practice it means the necessity of helping them, also by putting an end to their torment. While one should not shorten human suffering on the grounds of religions which identify suffering with punishment for one's sins in previous incarnations (so as not to extend the period of atonement),

[7] The dualism of bodily (earthly) life and spiritual (eternal) life was the reason behind cruel forms of converting Pagans to Christianity; because of saving a person's soul from hell their earthly body was tortured, and even killed. The practice of converting pagans (unbelievers, infidels) in itself showed that until they became Christians their lives had no meaning because they would not be saved. Fortunately, nowadays Christian communities reject these radical beliefs.

in Christianity suffering is an evil from which people should be saved. In practice it would mean the possibility of shortening earthly life as a way of saving people from excessive and unnecessary suffering (regardless of what theologians claim).

The incentive to sacrifice oneself for others is another element of Christian doctrine; dying for a fellow human is considered to be the highest form of sacrifice. Therefore, one who gives their life to save others follows Jesus' example most closely; consent to organ donation is also a form of such sacrifice. This example shows that Christianity can support the development of transplant medicine by inspiring people to selflessly sacrifice everything they have, including their bodies.

The fact, that regardless of declarations, followers of Christ do not in reality support the equality of all people, is a separate problem. It is showcased i.e. in the way candidates for priesthood are selected in the Roman Catholic Church, which does not ordain people who do not have a right hand (or even a thumb) due to the supposed inability to perform sacraments. This means that a person with a disability is considered less valuable than someone fully abled by the Roman Catholic Church; after all they are deprived of the possibility to perform priestly duties meaning that, according to Catholic theology, they cannot be an intermediary between God and people, leading them to salvation.[8] Another example of the belief that people are not indeed equal in the Catholic Church is the prohibition on female priesthood, as well as valuing people based on their religious affiliation. This sentiment is also apparent in the actions of the current Polish government which often invokes Christian values yet declined to welcome refugees (including women and children) from war-torn Syria, with the exception of Christians (Pędziwiatr, 2015, p. 2) suggesting that they view the life of a Christian as more valuable than the lives of non-believers or those who adhere to different religions. Breaking the principle of equality among people is further evident by the different levels of access to medical care among Christians. After all, the pope is provided with far superior treatment conditions than regular believers (who are sometimes more in need). While these differences are based on a rational assumption that the pope is more important to the Roman Catholic Church than other people, it still suggests that the rules of sanctity and equality of life are not fulfilled even within Christian communities; in that case they should not be an obstacle in changing the rules of transplant medicine following Singer's proposal.

If these remarks are valid, Singers position on donation can be justified not only by utilitarian arguments, but also ones based in Kantian ethics and Christianity. However, this does not necessarily mean that it should be implemented into medical practice due to the aforementioned problems in diagnosing complete and irreversible loss of consciousness. The issue of changing the definition of death or the donor rule concerns not only whether they are right but also their reliability in medical practice; this problem will be addressed in part two.

[8] In the past only the pope could allow a priest who suffered from a permanent disability to perform mass; for example, Isaac Joques who was tortured by the Iroquois was allowed by Urban VIII to perform mass despite his mutilated hands because he suffered the wounds as a martyr for Christ (Tüchle & Bouman, 1986, p. 212). The prohibition is surprising inasmuch as sacraments should not be understood as magical; turning bread into the body of Christ is not dependent on which hand is used to make the sign of the cross over it because it is not the priest's physical gesture that decides the power of the sacrament but rather God's action. Moreover, priesthood is also about preaching, absolving sins, and uttering Eucharistic formulas which do not require a right hand. Therefore, while it is understandable to prohibit a person without their right hand from driving a car or flying a plane, a similar prohibition on priesthood is hard to understand.

Part II: Practical proposals

Let us once again consider three cases: persistent vegetative state, locked-in syndrome, and people who artificially kept alive after brain death. There are two questions that need to be asked regarding each of them: are we dealing with people who are alive or dead? If they are alive, are we allowed to retrieve their organs for transplant purposes?

Persistent vegetative state means the patient's cerebrum is completely destroyed, however their brain stem, which is responsible for organic functions such as reaction to stimuli, digestion, and breathing, remains functional (Singer 2018, p. 159). Although the patient is not independent (they need to be fed), they do not require a respirator to remain alive. Due to the complete destruction of cerebral hemispheres they will never regain consciousness and therefore will never know what is happening to their body.

In this case, the question whether the patient is alive or not, is not easy to answer. While it seems obvious that they have died as a person (Lizza, 2018a, p. 8), it is just as obvious that they are alive as a biological organism (Nair-Collins, 2018, p. 27). If they breathe on their own (and fulfill other physiological functions) then they can hardly be declared dead; loss of consciousness alone is not enough for a pronouncement of death.

The answer to the second question is also difficult. While at first glance it would seem that there is no reason not to harvest organs from someone in a persistent vegetative state, this action would in fact be murder (Singer, 2018, p. 158). Regardless of whether there are moral arguments (not only utilitarian, but also Kantian and Christian) justifying this action, as I have previously indicated, it is not an obvious case. After all, there is no doubt that one cannot give away somebody's wealth to their heirs before they die (unless they consented to it) and it is unacceptable to accelerate their death in order to receive an inheritance sooner. If we are prepared to legally protect a patient's property, potentially harvesting integral parts of their body seems even more troubling. Therefore, it would seem that harvesting organs from people in a persistent vegetative state should not be allowed, at least until a social consensus is reached. Although it may seem that a social contract in this matter is a utopian idea, an attempt to negotiate different moral beliefs and legal systems should be made. Until we are able to work out at least the foundations of such a (preferably global) solution, a lot of caution is advised due to the danger of a slippery slope. Singer himself acknowledges that and gives the example of anencephalic children as potential donors (Singer, 2018, p. 162). Although Singer does not unequivocally solve the issue, he does suggest that we should be less conservative. However, it seems that the opposite is true; regardless of moral arguments (including judging how valuable the lives of irreversibly unconscious people are) when it comes to legally allowing for the killing of a living human (for the purpose of harvesting their organs) one should be highly cautious so as to avoid hurting somebody. If current medical technology is unable to reliably diagnose lack of consciousness (Lizza, 2018a, p. 8), then the question whether harvesting organs from people in a persistent vegetative state is allowed, should be answered in the negative.

Locked-in syndrome is an entirely different matter; those patients' brain stems are so damaged that they are unable to perform life functions, including breathing and therefore they need to be connected to a respirator to remain alive. However, since their cerebral hemispheres are intact, patients remain conscious, they are able to express emotions and even attempt to make contact with their environment, e.g. through blinking (Singer, 2018, p. 157).

The answer to the first question is obvious in this case; if a patient is conscious they cannot be declared dead despite the dysfunction of the body (Singer, 2018, p. 157; Lizza, 2018a, p. 7). The answer to the second question seems just as obvious; if the patient is alive as a person then their life must not be shortened for the purpose of organ donation. However, it is indisputable that

keeping them alive may result in unbelievable suffering and it is thus possible that they would prefer to die even if they are unable to communicate it. A potential declaration of will from earlier does not aid the decision about continuing or ceasing treatment because there is no guarantee that the patient in their current state would want to uphold their decision. The difficulty in this situation is the fact that whatever we do, we have no idea if we acted in accordance with the current will of the person and whether our actions were good or harmful to them. However, it is clear that in the case of locked-in syndrome the driving force behind a decision should be the good of the patient and not the potential benefits for transplant medicine. Thus, the answer to the question whether in this case the patient's organs can be harvested has to be negative. They could only be harvested as a side effect of shortening the patient's life to save them from unbearable suffering. The question whether they should be kept alive or allowed to die for their own good has to remain unanswered because we do not know what their current will is. Neither the Christian sanctity of life ethic (in the case of someone whose life is unbearable suffering this rule could be cruel), nor the Kantian imperative which says one should act according to rules they would want to be universal (after all we do not know what we would consider the right course of action in a situation in which we have not yet found ourselves and which we cannot imagine) can help in this situation. The utilitarian cost-benefit analysis is equally ineffectual because we cannot know what would be best for the patient, their loved ones, and society overall in this situation. The example of people with locked-in syndrome shows that in the most dramatic situations in which a person may find themselves our moral understanding fails; we do not know what we should do, knowing that whatever we decide could be wrong.

The third case is people who suffered from whole-brain death and thus irreversibly lost consciousness and their body is being artificially sustained (Lizza, 2018a, p. 1). Here, the answer to the first question seems obvious; if their consciousness is irreversibly lost and their body would not function without medical equipment, they should be considered dead. However, one could argue to the contrary that artificially sustaining an organism after brain death means that the patient is not dead (Nair-Collins, 2018, p. 28). It is supposedly proven by the fact that their body – connected to a respirator and fed through a stomach tube – remains in homeostasis, keeps a stable body temperature, and even fights infections (Nair-Collins, 2018, pp. 35–36). The respirator only provides the oxygen they are unable to acquire on their own, however it does not affect the functioning of the heart, liver, kidneys, or metabolism, all of which work on their own (Nair-Collins, 2018, pp. 35–36). Therefore, if breathing is the only function aided by a machine, then a brain-dead patient is no more artificially sustained than a diabetic who is alive because of the insulin they receive (Nair-Collins, 2018, p. 36).

This line of argument is difficult to agree with; after all there is no doubt that the situation of a brain-dead patient is radically different from someone in a persistent vegetative state who breathes on their own (Lizza, 2018b, p. 84). The difference between a brain dead patient and a diabetic or any other person who takes life-saving medicine (whether occasionally or on a regular basis) is even starker. In the case of a brain dead patient there is no chance of recovery, both in a biological sense and regaining consciousness; thus they can be considered dead whereas it is not an option in the case of a diabetic (Lizza, 2018b, p. 84).[9] The reason behind a brain dead patient being considered alive is the masking action of the respirator (Lizza, 2018a, p. 2).

If we concede that one is no longer alive after brain death, the answer to the second question should not be controversial because there are no serious moral arguments supporting the

[9] Lizza goes as far as to claim that a brain-dead patient is not a human being, just remains (Lizza, 2018a, p. 1); they are no more a person than an arm separated from the body and artificially sustained (Lizza, 2018a, p. 13).

prohibition on organ harvesting from a dead person. Therefore, if a brain-dead patient is being artificially sustained, we should agree to disconnect them from a respirator and other medical equipment; if they do not start breathing on their own, the suspicion that they were already dead will be confirmed. If they started to breathe on their own it would mean that they were misdiagnosed as brain dead because at least their brain stem remains functional; in this case we are dealing with a patient in a persistent vegetative state and thus, as concluded earlier, we should not harvest their organs.

This solution should not raise any serious moral or legal concerns. If we reject it, we risk a slippery slope, this time resulting in an inability to cease treatment at any time. If we prohibit disconnecting a patient from a respirator after brain death, we will likely be able to pronounce them dead only after the death of every cell in their body. This solution would not only exclude the possibility of any transplants, it would also require a change in the definition of a human being; a person would no longer be a rational, conscious, or social being, but simply a collection of live cells, which is hard to agree with.

One cannot exclude the possibility that the reason behind rejecting whole-brain death as the criterion for human death, is not medical development, or ethical concerns, but a hidden desire for immortality. The hope of conquering death appears at various times in history, even if it is expressed differently. In the 19th century, Nikolai Fiodorov, a Russian philosopher, proclaimed medicine as a science that would enable the bringing all of the dead back to life which would be the fullest expression of 'love thy neighbor.' For to love fellow humans would be to do anything in our power to keep them alive; since many people died already we have a responsibility to bring them back to life on Earth (Fiodorow, 2012). Cryogenics also seems to stem from the hope for some sort of immortality, or at least longevity. It seems that a similar hope lies at the foundations of arguments criticizing whole-brain death; it is possible that those making these arguments want to believe that thanks to medical progress, patients who are considered dead today could regain consciousness or even biological functions in the future. However, in light of current knowledge, these hopes are baseless.

In advocating for whole-brain death as a criterion for human death I also agree with Peter Singer that we need a broad social debate on changing this criterion and broadening the allowing of organ harvesting from biologically alive patients. Perhaps Laura Specker Sullivan is right when she argues for a definition of death that would have the least harmful ethical consequences (Sullivan, 2018, p. 67). However, due to the constant progress in medicine and the fluidity of our concepts (including the concepts of life and death) we should abandon hope for the discovery of one formula to solve all moral dilemmas. It is equally difficult to expect that any principle defining the conditions of organ donation will be final. They will all be temporary and require revisions in the future. Although introducing any new solution must be cautious to minimalize the risk of harm, caution also should not be paralyzing; inaction (including prohibiting organ harvesting from patients whose entire brain was destroyed) can have very negative consequences, sentencing to death people who could have been saved by a transplant. Taking all these arguments into account I advocate for organ harvesting from patients who suffered whole-brain death. However, I would postpone implementing Singer's proposal until medical procedures can diagnose irreversible loss of any human consciousness (meaning upper brain death) with a lesser risk of error than is currently possible.

Translated by Agnieszka Ziemińska

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