

Quote to note

"The president ... stressed the dangers of techniques that could lead to the horrible scenario of fused human-animal creatures."

— As reported in *The Washington Post*

Inside

Ask the ethicist

Organizational ethics: Physician compensation in managed care

3

The legal column

Rights and responsibilities of gamete donors

4

Ethics and literature

Blood and Bone: Poems by Physicians

Edited by Angela Belli and Jack Coulehan

5

Dialogue

The concept of brain death

6

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Feminist approaches to bioethics

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In order to be "feminist," an approach to bioethics must emphasize the role gender plays in the realm of healthcare. How does one's femaleness or maleness, one's femininity or masculinity, shape the way one thinks about and behaves within the worlds of medicine and science? And, of equal significance, how does one's gender affect one's power, prestige, status and personal value within systems and structures such as the hospital, managed care organization, hospice, physician's office, medical society and research institution? In an attempt to answer these questions, feminist men and women have developed a variety of ethical approaches, most of which fall under one of two headings: care-focused or power-focused.

Care-focused feminist approaches

Feminists who adopt care-focused approaches to bioethics often rely on the writings of Carol Gilligan and Nel Noddings, both of whom correlate being female with tending to cultivate such culturally-associated feminine virtues as caring, and being male with tending to cultivate such culturally-associated masculine virtues as justice. For example, while studying how each of 29 women decided whether it was right or wrong to have an abortion, Gilligan noted that, as a group,

these women focused on how their decision would affect their relationships with those persons to whom they were already related, as well as to the future persons within their wombs. On the basis of this and several other empirical studies of women's and, more recently, men's moral reasoning patterns, Gilligan concluded that for a variety of cultural reasons, women typically utilize an ethics of care which stresses social relationships and personal responsibilities, whereas men typically employ an ethics of justice which stresses individual rights and contractual duties.¹

In a similar vein, Nel Noddings writes that traditional ethics have emphasized theoretical, as opposed to practical, modes of reasoning, favoring things that tend to be valued by men (independence, autonomy, intellect, hierarchy, domination, asceticism and war) as opposed to things that tend to be valued by women (interdependence, community, connection, sharing, emotion, body, trust, absence of hierarchy, nature, process, joy and peace).²

Eschewing the interpretive style of reasoning which is characteristic of the humanities and social sciences, most traditional ethicists have instead embraced the deductive-nomological style of reasoning which is characteristic of mathematics and the natural sciences. They have favored

(Continued on Page 2)

weighing the principles of autonomy, beneficence, nonmaleficence and justice against each other, hoping to discover through their rational powers which of these principles ought to take precedence over others in a given situation. In contrast, feminists who espouse care-focused approaches to bioethics have relied on their emotional resources — on human sentiments such as empathy and on what Noddings calls “human caring and the memory of caring and being cared for ...”³

Feminist care-focused approaches to bioethics are not unproblematic. The virtue of care can be distorted. People can care too much about others and not enough about themselves, they can use caring words to manipulate people to get them to do things that are not in their own best interests or they can care too much about one person and not enough about another. Before care is hailed as healthcare’s quintessential moral virtue, its relationship to justice, its primary competitor, must be better understood. I, for example, believe that “care” is not some sort of principle, rule or guideline that trumps “justice,” but the passion or motive that makes us want to be just in the first place.

Power-focused feminist approaches

Feminists developing power-focused approaches to bioethics also value the virtue of care. However, as they see it, care cannot blossom as a moral virtue in an unjust society in which sexism, racism, ethnocentrism, classism and heterosexism thrive. Therefore, the most important task for feminist power-focused bioethicists is to expose and reform all healthcare systems, structures, institutions, principles, policies and procedures which neglect, trivialize or ignore women’s and other vulnerable groups’ interests, issues and identities.⁴ In order to accomplish this ambitious goal, these feminists have sharpened the so-called woman question: “Why is this man’s world, not woman’s world?” into an analytical tool for the purpose of “identify[ing] the gender implications of rules and practices which might otherwise appear to be neutral or objective.”⁵

Aided by this probing instrument, power-focused feminist bioethicists ask, for example, why women have been excluded

from so many clinical research studies; why so few women are hospital presidents and chiefs of medical staffs; why such professions as nursing and social work are female dominated; and why women are far more likely than men to fall prey to eating disorders like anorexia or bulimia. The ways to raise questions about the role gender (masculine and feminine) plays in our everyday lives are many indeed — a fact that power-focused feminist bioethicists interpret as a sign of how deeply gendered our society is, and how easily most people accept as “natural” the unjust megastructure of male domination and female subordination which human beings have gradually constructed and, for the most part, successfully internalized.

An integrated perspective

Both care-focused and power-focused feminist bioethicists use ways of thinking which promise to eradicate those invidious power relations that make our healthcare system less than just, and far from fully caring. For example, Dr. Joanne Lynn’s remarkable essay, “Travels in the Valley of the Shadow,” reveals an integrated perspective. Her story concerns an elderly man, whom she calls Mr. Phillips, who apparently was a victim of Alzheimer’s type dementia and was unable to swallow. After she inserted a feeding tube and gave instructions to the home-care nurse about restraining him, Mrs. Phillips became distraught. She sobbed that she couldn’t “tie” her husband down to their bed. Suddenly Dr. Lynn realized that Mr. Phillips was not her “problem of nutrition and hydration,”⁶ but Mrs. Phillips’ husband, lover and partner. To tie him down to his bed was not, therefore, a straightforward “mechanical solution to the problem of keeping a feeding tube in place, but a deeply offensive abuse ...”⁷

Reflecting on Dr. Lynn’s story as a feminist bioethicist, it seems to me that she initially acted like the traditional non-feminist physician. She made her decision as the physician who knows what is best for her patient. But when Mrs. Phillips broke down, Dr. Lynn recognized how little thought she had given to the effects of her decision on the relationship between Mr. and Mrs. Phillips, let alone her relationship to the Phillipses. Locked into her own world, Dr. Lynn had failed to see the world from the position of the very vulnerable

couple. A securely-fastened feeding tube might be the treatment of medical choice, but it was not what the Phillipses required. Only Dr. Lynn’s ability and willingness first to hear, and then to converse with Mrs. Phillips permitted her to see that the right treatment for Mr. Phillips was not artificial food and hydration but the healing ministries of his wife. By sharing her power with the Phillips family, by admitting the ultimate authority of their own fundamental good, Dr. Lynn stopped acting like an oppressor and found a treatment for Mr. Phillips with which everyone, including herself, could live. She removed the feeding tube, revoked her restraint orders, and let Mr. Phillips “live as well as he had been living as long as it lasted.”⁸ He died at home two months later.

Clearly, care-focused and power-focused feminist approaches to bioethics, despite their differences, can and do merge in the decisions and actions of people like Dr. Lynn. Although Dr. Lynn did not describe her decision and action in this case as feminist, it is, nonetheless, the decision a feminist would make and the action a feminist would take. In order to make the world of healthcare one that structures and organizes itself so as to serve men and women — and, by parity of reasoning, people of different races, ethnic backgrounds, socio-economic classes, religions and cultures — equally well, feminist bioethicists must develop ways of thinking which permit people with differences to establish caring relationships among themselves.

Feminist bioethicists do not regard their many-faceted approaches to bioethics as consisting of self-contained bioethical theory meant to rival traditional bioethical theories, but as a series of corrective lenses that are meant to improve moral vision. Thus, feminist bioethics invite all bioethicists to reflect upon the status of women and other subordinate groups in the realm of healthcare. By focusing on issues related to gender, but also to class and race, for example, bioethicists will be able to play a more effective role in making the realm of healthcare a truly just world which fully cares about women’s interests, issues, values and experiences as much as men’s — indeed, a world that cares passionately about anyone who finds himself or herself deeply in need of the healing that only caring heads, hearts and hands can deliver. □

(References on Page 8)

Ask the ethicist:

Organizational ethics: Physician compensation in managed care

Question: Members of a managed care organization (MCO) pay a higher premium for a point-of-service (POS) product because it allows out-of-network care and choice of specialists without referral by a primary care physician.

The MCO is considering two financial arrangements. One would give the extra POS premium dollars to provider groups who would pay for out-of-network services; they would retain unused funds, but be at risk for any losses. Providers would be motivated to keep costs down, but they would be at risk without the power to control patient choices. They would be motivated to discourage the use of outside services for which members have paid a higher premium.

Under the second arrangement, the MCO would use the higher POS premium to pay for out-of-network care; the MCO would retain profits and be at risk for losses. This plan might reward primary care doctors for sending patients out-of-network because more expensive specialty care would not be charged against their risk pool.

How would you advise the MCO?

Response: The MCO's dilemma could be largely avoided with a different financial structure for the point-of-service product. Both proposed point-of-service plans present a major perverse incentive for patients, who apparently pay a single premium entitling them to unlimited forays outside the network. They paid, so they want their money's worth. Then the MCO plan must figure out how to put on the brakes, thereby precipitating the ethical dilemma of whether to pit primary care physicians against their patients, or the MCO against its primary care physicians. Instead of the one-time premium, the MCO should motivate patients themselves to weigh the value of each prospective out-of-network excursion.

In one fairly common option, the health plan asks the enrollee to pay a higher copay, such as 20 percent, for each out-of-network excursion. For people with limited incomes, that copay can make the out-of-network option prohibitive. A cap on a patient's total out-of-pocket expenses, such as \$2,500 per year, would make out-of-network care more affordable

— but once patients reach the cap, there would be no further incentive to be judicious about out-of-network utilization.

In a better approach, the MCO could establish a fair and reasonable fee schedule for each out-of-network service. The patient would be responsible to pay any charges that exceed those established fees, but would have the option to negotiate so that, if the out-of-network provider is willing to accept the established fee as payment in full, the patient will owe nothing extra. The plan has controlled its costs and patients still have the opportunity to go out of network and to limit their own expenses through negotiation.

To limit the volume and intensity of out-of-network services, the MCO can remind the patient that, as with any other care, it does not cover services it deems unnecessary or inappropriate. In most cases the patient will already have authorization for specialty care, so the question is only who should provide it. Alternatively, the patient can request pre-certification. Patients generally seek out-of-network physicians for elective services, not emergency care. In this setting there is usually more time for patients to discuss, negotiate and think carefully about why and whether it is important in this instance to seek services out of network.

In its current financial structure, the point-of-service option will only pose a serious financial problem if patients seek care out of network on a fairly widespread basis. In that case, the more important question is why patients are so eager to leave the MCO's network; often the answer to that question is mistrust.

Mistrust can come from physicians or from patients. For physicians, it is difficult to be enthusiastic about referring someone to a complete stranger — and this lack of personal endorsement is hardly reassuring to patients. Also, when specialists are just names on a list, communication and coordination tend to suffer.^{1,2}

To mitigate this problem, the MCO can make ongoing efforts to help its primary care physicians and specialty physicians meet, discuss items of common concern, and build mutual respect. The health plan should keep its physician networks as stable as possible over time by negotiating reasonable terms that foster

physicians' willingness to remain, and by deselecting physicians only for good cause. And the plan should recognize that in general, adequate access to specialist care may be medically and economically superior in the long run.³

Defections also can come from patients' mistrust, directed either at primary care physicians or at specialists. If the health plan assigns primary care physicians rather than letting patients choose, or if the patient has no primary care physician and just sees whoever is on call that day — or if the patient must find a new primary care physician because his employer switched health plans — it will be difficult to build personal relationships. If the patient does not know his physician well enough to trust her judgment, then that physician's most heartfelt assurance that a specialist is well-qualified may still prompt skepticism. Accordingly, health plans should create opportunities for patients to choose and stay with primary care physicians they like.

Patients' mistrust could alternatively focus on specialists. Obviously, health plans must choose specialists on the basis of quality, not just fee discounts. But it also must let patients know about that quality, perhaps by providing detailed profiles of all their physicians, including their education and training, statements about his or her goals as a physician, and even personal information about family and hobbies.

Promoting relationships and communication is part of a more basic principle: in these unsettling times, trust must be earned, not presumed.

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Outcome: The managed care organization hasn't made a decision yet. □

¹ Roulidis AC, Schulman KA. Physician communication in managed care organizations: opinions of primary care physicians. *J Fam Pract* 1994;39:446–51.

² Epstein RM. Communication between primary care physicians and consultants. *Arch Fam Med* 1995;4:403–09.

³ Donohoe MT. Comparing generalist and specialty care: discrepancies, deficiencies, and excesses. *Arch Intern Med* 1998;158:1596–1608.

The legal column: Rights and responsibilities of gamete donors

By Jane Greenlaw, JD

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John and Luanne Buzzanca, a California couple, wanted a child but were infertile. Using the resources that modern medicine and science offer, the Buzzancas decided to have a child using a gestational surrogate. They entered into a signed agreement whereby they provided an embryo created from donor gametes (an egg and a sperm), which was implanted into the uterus of a woman who would carry the pregnancy to term and then allow the Buzzancas to adopt the child. The Buzzancas separated shortly before the child was born and Luanne adopted the child, Jaycee. When Luanne then went to court seeking child support from John, he argued that the court had no jurisdiction since Jaycee was not a “child of the marriage.” An appellate court rejected this argument, ruling that the signed agreement warranted a finding that John was Jaycee’s father. When the case was returned to the lower court, the judge then ruled that neither John nor Luanne was Jaycee’s legal parent. This ruling has recently been overturned by the California Court of Appeals.¹

The Buzzanca case illustrates the confusing and disparate results reached when there are gaps between technology, medical practice and the law, and highlights the need for regulation and legislation in this area.

Who are parents and what are their responsibilities to their offspring? These have traditionally been relatively simple and straightforward questions. Historically, disputes about parentage were almost exclusively questions about paternity and involved children born to unmarried women or to married women who were alleged to have had adulterous affairs. Common law provided that a child born to a married woman was presumed to be the child of her husband, a presumption designed to ensure the “legitimacy” of children and said to be “one of the strongest and most persuasive known to the law.”² Most states allowed the woman’s husband to offer proof to overcome the presumption, but this was difficult to do prior to the availability of modern blood tests. Even then, blood tests were conclusive only in ruling out paternity; the availability of DNA testing has only recently allowed for conclusive proof of parentage.

Early treatment for infertility brought about some statutory modification of the common-law presumption of paternity. The oldest form of assisted reproduction, artificial insemination using donor sperm (AID), is a practice that has been used for over one hundred years to treat male factor infertility. The usual practice was for the anonymous donor’s semen to be mixed with the semen of the woman’s husband and placed near the woman’s cervix at a time when conception was most likely to occur. In virtually all United States jurisdictions the practice itself was largely unregulated, although many states passed laws designed to prevent or resolve paternity disputes resulting from AID. Most of these laws were based on the Uniform Parentage Act (UPA), a model statute designed to guide the development of state laws, and provided that when a married woman was artificially inseminated by a licensed physician with the written consent of her husband, the resulting child was the legal child of her husband. Although the UPA additionally recommends that the state law should explicitly divest the semen donor of parental rights and responsibilities, some states did not follow the recommendation. The reason for this is unclear; it may have been thought that the donor’s rights were implicitly extinguished or it may have been thought unnecessary because of the anonymity of semen donation.

Recent social changes and developments in the treatment of infertility have rendered the presumption of paternity a quaint legalism, obsolete and incomplete. A recent report by the New York State Task Force on Life and the Law examines the impact of assisted reproductive technologies (ARTs), analyzes the gaps in existing laws, and makes recommendations for appropriate changes.³ Although its recommendations are for specific changes in New York law, they can be generalized because they address public policy issues not yet systematically addressed.

A major inadequacy of existing laws in most states is that there are no provisions about children born as a result of assisted reproductive technologies other than artificial insemination. The Task Force’s simple recommendation is that the statutes

be amended to provide that when a married woman undergoes any assisted reproductive procedure, the resulting child is the child of her husband, provided the procedure was performed by a licensed physician with the husband’s consent.

Another recent change is that gamete donation is no longer limited to sperm. Donor eggs are now commonly used in ARTs, and their use has been enhanced by cryopreservation techniques. Typically, state laws address only paternity and have not been amended to address questions of maternity. For parity, the Task Force recommended that state laws should specifically provide that a woman who gives birth to a child conceived with a donor egg is the child’s legal mother.

An additional development is that gamete donation can no longer be anonymous because of the risks of transmitting infectious diseases or genetic defects; regulations and standards of practice require record keeping to permit the linking of gamete donors and recipients. The ability to trace donors (and for donors to trace their offspring) highlights the inadequacy of laws that do not explicitly extinguish donors’ parental rights and responsibilities — in the absence of such a provision there is uncertainty and ambiguity. A related social development is that women who do not have husbands are becoming pregnant through artificial reproductive technology. Some are fertile and choose artificial insemination because they prefer to achieve a pregnancy through noncoital means, and others are infertile and will accept the full array of assisted reproductive techniques, including *in vitro* fertilization (IVF). For these women, the presumption that a child is the legal child of its mother’s husband clearly does not apply. In these situations, the ability to trace the gamete donor(s) and the ambiguity of the law with regard to parental rights and responsibilities of gamete donors is likely to be even more problematic. Accordingly, to address both of these issues, the Task Force recommended that state law should explicitly allow gamete donors to relinquish, in writing,

(Continued on Page 8)

Ethics and literature: *Blood and Bone: Poems by Physicians*

Edited by Angela Belli and Jack Coulehan
University of Iowa Press, 1998, 160 pages

The title, "Doctors Have Feelings Too," shows above the reprint pocket in the kiosk. I'm in the doctor's lounge of the hospital that I practiced in for 30 years, and have been retired from for four. This lounge differs from the one my generation eagerly gathered in to tell stories, to share experiences from our practices.

Although larger, more expensively furnished and decorated, this lounge has lost its exuberance. The mood is sober, doctors come and go, pretty much alone, they carry briefcases and read the *Wall Street Journal*. I'm uncomfortable here; I think these doctors are, too. I get up and go over to the kiosk. There are, maybe, 20 reprints with titles like, "Support Groups: An Important Aspect of Medical Education," "Physician Satisfaction With Patient Encounters," "Meaningful Experiences in Medicine," and "Reclaiming the Joy of Medicine."

I know what is going on here: the medical staff office is trying to keep its doctors from losing their grip as they negotiate an anxiety-ridden bridge to, or around, managed care. And I have this urge to write, *try poetry, you'll like it*, on the back side of one of these papers, and slip it into an empty slot.

Last week I got my hardcover copy of *Blood and Bone: Poems by Physicians*. I have it with me: one hundred poems by 32 contemporary physicians from Ireland, Great Britain, Canada, and the USA; some retired, most still practicing. And while not one poem in this collection speaks to the more stressful components of today's healthcare enterprise, economics and the sense of devaluation, they do address the more enduring values, values that will provide meaning long after managed care either matures or fades. They do so by sharing and celebrating, in an accessible

poetic language, the full range of emotions that arise from acts of doctoring.

I remember reading, a few years back, that the writing of poetry is directly related to the increase in stress within a given population, for example, the medical profession. Although I cannot recall the source of that contention, Charlene Breedlove, in her editorial introduction to *Uncharted Lines: Poems from the Journal of the American Medical Association* (Boaz Publishing Company, 1998), another fine anthology, seems to agree. She writes, "Poetry related to medicine . . . has burgeoned over the past decade, becoming a recognizable genre in its own right." And further on, giving one explanation for this response, she writes, "The wonder in this may be simply that in the face of deep uncertainties, poetry remains the language of choice, the only language that gives solace to the soul and revives the imagination."

Leafing through *Blood and Bone*, I chose two of the shorter poems and a few lines from a longer one to show something of this language.

"Youth"

by Vernon Rowe

*She glided into
the office, lavender,
brilliant, springtime,
blonde. Her eyes
clear, hopeful
in the face
of fear.*

*The only things betraying
her seventy-two years
were a few wrinkles
and a minimal tremor,
and we can fix those.*

Review by John L. Wright, MD
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"A Letter to William Carlos Williams"
by George Young

*We know, Doctor Williams, you and I,
as we go
from patient one to next,
thumb
the rumpled charts, cough
nervously and look away from worried eyes,
what
we will see—*

*What is, is, and it is
just this: the
truth
of blood and flesh we wrestle with:
sheer, brute, singular,
wounded—
ourselves.*

And lastly, these lines from John Stone's, "Gaudemus Igitur"

*For you may need to strain to hear the
voice of the patient in the thin reed of his
crying
For you will learn to see most acutely out of
the corner of your eye to hear best with your
inner ear
For there are late signs and early signs
For the patient's story will come to you
like hunger, like thirst*

I can think of no more suitable encouragement for the doctors who pass through hospital lounges than the words with which the editors of *Blood and Bone* close their introduction: "In medicine and health care today — perhaps this is a symptom of the 1990s in general — we are worried about getting the news, keeping up to date, changing with the times. But the nourishment of poetry is right there in front of us, at the heart of our daily work." □

Dialogue:

The concept of brain death

In his article on the concept of brain death (*Medical Ethics Newsletter*, Fall 1998), James Bernat makes several claims. First, he argues brain death is misleading as a descriptive term. Second, he believes death is a term that refers to a specific biologic event, and the most reasonable definition of death is “permanent cessation of the critical functions of the organism as a whole.” He asserts that the only criterion that meets this definition is “the permanent cessation of all clinical functions of the whole brain.” Bernat supports the “dead donor rule” — that organ procurement can neither be the cause of death nor proceed before the patient dies — because he feels it is necessary to maintain public confidence in organ procurement. He is concerned that non-heart-beating organ donors might be alive because “hearts could be restarted before all brain function had been lost.” Following this line of reasoning, we assume — given his belief that permitting pre-death donation will undermine confidence in organ donation — he must believe non-heart-beating organ donation is poor public policy.

Each of these assertions is extremely controversial and has been extensively discussed in the recent literature.¹ While we focus our attention on his concern about non-heart-beating organ donors, we do have several questions regarding Bernat’s position.

First, how can Bernat be so confident that there must be a single unifying criterion for death? Our society has been unable to define when life begins, not due to disputed facts, but because of differing values. Are questions about the criteria for death matters of biologic fact or are they value-laden questions about which reasonable persons may disagree?

Second, Bernat suggests that death requires cessation of the critical functions of the organism as a whole, but shouldn’t the definition require cessation of *all* critical functions of the organism as a whole? If the brain is the critical integrating organ, how does he explain individuals who have been declared dead using neurologic criteria surviving for years; some of whom have gone through complex hormonal and growth changes such as puberty and pregnancy.²

Third, how do we decide what constitutes the brain’s critical functions? Bernat equates the “critical” with the “clinical” functions of the whole brain. Why? While he includes hypothalamus in the critical functioning of the brain, he does not require testing its neuroendocrine function.

Finally, given that with time, we have permitted withdrawal of life-sustaining treatment before “brain death,” why is Bernat so convinced that our society will not tolerate organ procurement from nearly dead individuals? Because both death and organ donation are value-laden propositions, might not such viewpoints change?

Regarding non-heart-beating organ donation, first let us say that if we had to do it over again, we would not use this term. While descriptively accurate, the term has engendered as much confusion as has the term “brain death.” Today, most organs are procured from individuals who are declared dead using neurological criteria and whose hearts are still beating at the time of procurement. Recently there has been renewed interest in procuring organs from individuals who are declared dead using cardiopulmonary criteria. Their hearts are not beating at the time of procurement (thus the name, non-heart-beating organ donors). We are concerned that this term has increased the confusion over whether these individuals are “really dead” and wish we had insisted on a different terminology, for example, “organ procurement from dead individuals certified dead using cardiopulmonary criteria.”

Second, non-heart-beating organ donation is not new. Prior to the acceptance of “brain death,” non-heart-beating organ donors were a common source of organs for transplantation.³ Interestingly, at that time, there was no controversy regarding the death of those donors. Instead, the controversy questioned whether “brain dead” individuals were really dead. Non-heart-beating organ donation was largely abandoned because the organs did not perform as well as those procured from brain dead donors. Not every center stopped non-heart-beating organ donations. For example, in Wisconsin it has always been a source of kidneys.

There are two approaches to limiting ischemia, or lack of blood supply, to an

organ and thus ensuring that viable organs are procured from non-heart-beating organ donors.⁴ First, ischemia can be limited by controlling the time and place of death. So called “controlled non-heart-beating organ donors” was developed in response to families’ requests to donate their loved one’s organs after a decision to withdraw life-sustaining treatment. The Pittsburgh Protocol was the first published policy detailing and justifying the procurement of organs in such situations. Second, quickly infusing cold preservatives after death decreases warm ischemia. This method must be used in uncontrolled circumstances when death is unexpected, but can be utilized in controlled situations as well.

The most controversial issue in non-heart-beating organ donation is when death can be declared. The University of Pittsburgh Medical Center’s policy for non-heart-beating organ donors requires two minutes of absent circulation, apnea and unresponsiveness. There is scientific support for this position. First, there is no brain function within 15 seconds after the heart stops beating in normothermic patients. Second, the little data available demonstrate that auto-resuscitation — the heart restarting on its own — is very rare and never occurs after more than two minutes.⁵ Tomlinson argues that because these individuals refuse resuscitation, it is unethical to attempt to restart the heart. Therefore they are dead.⁶

Critics have objected to this formulation in a number of ways. The Institute of Medicine questions the power of the data regarding the potential for auto-resuscitation and recommends a longer waiting time.⁷ Bernat argues that the Pittsburgh policy relies on a faulty definition of irreversible. Just because one chooses to not try to restart the heart does not mean it cannot be restarted. Until the heart (or the brain) loses the potential for resuming function, the loss is not irreversible and the patient should not be declared dead. Finally, because of the dichotomous certifying criteria, one may argue that a patient can be dead using cardiopulmonary criteria, but if such an individual was immediately placed on a cardiopulmonary bypass machine, some brain function may resume. This possibility led individuals at

the First International Conference on non-heart-beating organ donation to call for requiring ten minutes of pulselessness prior to declaring death.

We agree with the critics that non-heart-beating organ donor policies raise important questions regarding the definition of irreversibility, highlight the tension between brain and cardio-pulmonary-based criteria for death, and force re-examination of the data regarding auto-resuscitation. While we believe the Pittsburgh Protocol offers a conceptually and pragmatically defensible answer to these questions, we understand the controversy is unlikely to go away. Like the debate regarding the definition of death and criterion for "brain death," they reflect the socially and philosophically ambiguous nature of death. Finally, it seems that the current growth in non-heart-beating organ donation may render moot Bernat's concern about its public policy implications.

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¹ Youngner SJ, Arnold RM, Schapiro R (eds): *The Definition of Death: Contemporary Controversies*. Baltimore, MD: Johns Hopkins University Press, 1999 (in press).

² Shewmon DA. Chronic "brain death" meta-analysis and conceptual consequences. *Neurology* 1998;51:1538-45.

³ DeVita M, Snyder J, Grenvik A. History of organ donation by patients with cardiac death. *Kennedy Inst Ethics J* 1993;3(2):113-29.

⁴ Youngner SJ, Arnold R. Ethical, psychosocial, and public policy implications of procuring organs from non-heart-beating cadaver donors. *JAMA* 1993;269:2769-74.

⁵ DeVita M. *The Death Watch*. Unpublished.

⁶ Tomlinson T. The irreversibility of death: reply to Cole. *Kennedy Inst Ethics J* 1993; 3(2):157-65.

⁷ *Institute of Medicine: Non-heart-beating Organ Transplantation: Medical and Ethical Issues in Procurement*. Washington, DC: National Academy Press, 1998.

Dr. Bernat responds

Drs. DeVita and Arnold highlight several areas of current controversy that the brevity of my article permitted me to address only tangentially. I have considered them in greater detail elsewhere.¹ I will respond briefly to two of their questions.

Their claim that the definition and criterion of death are "value-laden propositions" underscores that any analysis of a biosocial issue must carefully distinguish between those elements contingent on the science of biology and those related to the creation of social policy on the biological issue. We can only study, describe, and try to understand the scientific facts of biology; we cannot change or contrive their objective reality to fit social agendas or for other purposes.² However, we remain free to design and continuously alter our public policy about biological issues as a result of societal debate on both consensually held values and pragmatic issues of what works best for society. The analysis of the definition and determination of death contains both scientific and social policy elements but, unlike in the question posed by Drs. DeVita and Arnold, they must be clearly separated for adequate analysis.

Because death, like life, fundamentally is a biological phenomenon, determining the definition and criterion of death are biophilosophical tasks that can be studied and modeled but cannot be assigned arbitrarily. Much of the current scientific debate on the coherence of the concept of "whole brain death" as a formulation of death results from our incomplete understanding of the theoretical biology of complex organisms and their emergent functions. Our current models of complex living systems remain primitive, regrettably including the concept that I endorse of the "organism as a whole." But it is from this biological perspective that I hold that my account of the definition and criterion of death best captures the objective reality of the demise of the human organism. Recently, Julius Korein has further consolidated this view using the thermodynamic concept of the brain as the critical system of the organism.³ Nevertheless, we need greater sophistication in our understanding of the theoretical biology of complex systems to finally settle this scientific debate.

Whether "whole brain death" or an alternative concept of death conforms to our consensually held values or works best for our society, however, remains an active but entirely separate point of public policy

debate. This choice may evolve over time based upon changing public opinion, and may vary among societies. Here, unlike in the biological question, values and pragmatism become relevant. In this regard, I believe that Drs. DeVita and Arnold would concur that the current widespread acceptance of the "whole brain" concept of death by every jurisdiction in the USA and most Western nations is *prima facie* evidence that it represents a workable and coherent public policy. Similarly, the dead donor rule represents a successful public policy because it has been accepted around the world as an axiom for determining candidacy for multi-organ procurement for transplantation.

The non-heart-beating organ donor protocols are an innovative and creative solution for increasing the supply of scarce organs available for transplantation. When I pointed out in the article that the donors of such organs may not be unequivocally dead at the point of donation (because of the potential reversibility of their illness and the fact that death, by definition, is irreversible) this was merely acknowledging a biological fact. Whether we as a society are willing to overlook this fact, because of the obvious social benefits gained by endorsing the practice of non-heart-beating organ donors, is a question of policy. As Drs. DeVita and Arnold predict, the consensus may well turn out that because these patients will neither be actively resuscitated nor will auto-resuscitate, they are "as good as dead" for the purposes of organ transplantation. It is entirely possible that our society may decide that incipient death is close enough to actual death for us to construct a workable and acceptable public policy on multiorgan procurement. But, as I noted in the article, despite many years of successful operation, public confidence in our current system of organ procurement remains precarious and I fear that altering the dead donor rule could backfire. □

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¹ Bernat JL. A defense of the whole-brain concept of death. *Hastings Cent Rep* 1998;28(2): 14-23.

² Wilson EO. *Consilience: The Unity of Knowledge*. New York: Alfred A. Knopf, 1998:45-65.

³ Korein J. Ontogenesis of the brain in the human organism: definitions of life and death of the human being and person. *Adv Bioethics* 1997;2:1-74.

Feminist approaches (Continued from Page 2)

- ¹ Gilligan C. *In a Different Voice*. Cambridge, MA: Harvard University Press, 1982:76–92.
- ² Jagger AM. Feminist ethics: projects, problems, prospects. In Card C (ed): *Feminist Ethics*. Lawrence, KN: University of Kansas Press, 1991:85–90.
- ³ Noddings N. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley, CA: University of California Press, 1984:1.
- ⁴ Jagger AM. A feminist ethics. In Becker L, Becker C (eds): *Encyclopedia of Ethics*. New York: Garland, 1992:363–364.
- ⁵ Bartlett KT. Feminist legal methods. In Weisberg DK (ed): *Feminist Legal Theory*. Philadelphia, PA: Temple University Press, 1993: 551.
- ⁶ Lynn J. Travels in the valley of the shadow. In Spiro HM, McCrea MG, Peschel E, St. James D (eds): *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*. New Haven, CT: Yale University Press, 1993:43–44.
- ⁷ Ibid, p. 44.
- ⁸ Ibid, p. 44.

The legal column (Continued from Page 4)

their parental rights and responsibilities, effective at the time of donation and irrespective of the marital status of the recipient.

Finally, surrogacy agreements and donated embryos make it possible for women to give birth to children not genetically related to them (or their husbands). It is beyond the scope of this article to discuss the complexities of state laws regarding surrogacy agreements. However, it is worthy of note that the Task Force recommendation is for the law to provide that a woman who gives birth to a child is the child's legal mother, and further, to provide for legal procedures and standards that would apply in a dispute.

The Task Force recommendations were guided primarily by the interests of children who will be created by assisted reproductive technologies. To that end, the stability of families, the desirability of eliminating or reducing ambiguity about parentage, and the importance of having safe means of creating families are all factors that led to the Task Force recommendations. The goal is to protect parents and children from claims of parental rights by gamete donors, and to protect gamete donors from unwanted, unexpected parental responsibility.

As is often the case in medicine, it is likely that technology will outpace the development of the law in this area. Furthermore, it is likely that assisted reproductive technologies will continue to be the focus of much public policy debate. □

- ¹ Jaycee v. Superior Court, 61 Cal. App. 4th 1410 (1998).
- ² State ex rel. H. v. P., 90 A.D.2d 434, 437, 457 N.Y.S.2d 488, 490 (1st Dep't 1982) (quoting Matter of Findlay, 253 N.Y. 1, 7 (1930)).
- ³ New York State Task Force on Life and the Law. *Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy*. New York, NY: April 1998.

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