

Organ Procurement: A Case for Pluralism on the Definition of Death

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Abstract

Brainstem death has, since 1976, been accepted by the medical establishment in the UK as the means for defining death. Its subsequent endorsement by the courts now makes it lawful for the life-sustaining medical treatment of patients who have been diagnosed as brainstem dead to be terminated and for their organs, particularly vital organs, to be removed for transplantation. However, this definition of death has never been universally accepted. For Roman Catholics, Muslims and Orthodox Jews for instance, death is associated more with the cessation of breathing. For them, terminating a mechanical ventilator upon the pronouncement of brainstem death could therefore be tantamount to murder. Yet this definition has been and continues to be the sole one used across ICUs in Britain to ascertain death. This article puts forward the view that in an increasingly multi-religious society, a matter as crucial as when one's life ends should undergo an extensive Parliamentary debate where competing faith-based viewpoints could be properly considered. English law should, following this, endeavour to facilitate and protect patients' right to choose which concept of human death they would like to be applied to their deaths.

I. Introduction

Death is a concept which has traditionally been equated with the cessation of breathing and heartbeat. However, the arrival of the mechanical ventilator and the development of intensive care medicine after the Second World War have now provided doctors with the ability to save or prolong the lives of those suffering from respiratory failure, when death would otherwise have occurred. This has given rise to the unprecedented question of whether and when life-sustaining medical treatment could be withdrawn to prevent doctors being at the receiving end of a murder charge.¹ Related to this is the issue of when such patients would be eligible as a source of cadaveric organs

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¹ F.G. Miller & R.D. Truog, *Death, Dying, and Organ Transplantation: Reconstructing Medical Ethics at the End of Life* (New York: Oxford University Press, 2012) 1.

for purposes of life-saving transplantation. If those organs could previously be retrieved only after cardio-respiratory arrest, these technologies now enable doctors to procure them from patients whose respiration and cardiac function are still maintained on the ventilator.² As this allows their organs, particularly vital organs, to remain fully-functional and perfused with oxygenated blood, it helps ensure that the organs are in optimal condition for transplantation when they are removed. This prospect gave birth immediately to the 'dead donor rule' (DDR). A derivative of the established medical norm that doctors must not kill their patients, it forbids vital organs being retrieved from donors who are still alive, thereby leading to their deaths. In other words, death needs to precede and be a prerequisite for, vital organ donation.³ But if the view is taken that organs cannot be removed until the person is dead, it is important to know exactly when death occurs in these highly technical environments. These developments have therefore prompted the need for a far more precise determination of death and standardised criteria for its diagnosis. The medical fraternity in the UK responded to these challenges by accepting 'brainstem death' as the new definition of death at the Conference of the Medical Royal Colleges and their Faculties in 1976. This definition, and the Code of Practice they issued for the diagnosis of brainstem death, have since been applied across ICUs in the UK. They have also been endorsed by the English courts in a number of cases, thereby making the medical standard of death the legal standard of death.

However, would a single understanding of the point of death be suitable for medico-legal purposes within a multi-faith society like Britain? This article will explore the religious objections to the notion of brainstem death and puts forward the argument that there is a need for parliamentary debate on the definition of death where competing faith-based viewpoints could be heard and be given legal protection. The discussion will be approached in the following manner. Part 2 will trace the historical development of the concept of brainstem death from the legal perspective, focusing on the endorsements that have come from judges in response to specific scenarios which have appeared before them for ruling. Part 3 looks at the objections which have been expressed by religious communities against the use of brainstem death as the determinant of death. It then investigates how a pluralistic approach to the definition of death has

² S. Ridley et al., 'UK Guidance for Non-heart-beating Donation', *British Journal of Anaesthesia* 95, no. (5) (2005): 592; D.W. Evans, 'Seeking an Ethical and Legal Way of Procuring Transplantable Organs from the Dying without Further Attempts to Redefine Human Death', *Philosophy, Ethics, and Humanities* 2 (2007): 11. For an interesting discussion of the history of transplantation, see C. Machado et al., 'The Concept of Brain Death Did Not Evolve to Benefit Organ Transplants', *Journal of Medical Ethics* 33 (2007): 197.

³ T.S. Huddle et al., 'Death, Organ Transplantation and Medical Practice', *Philosophy, Ethics, and Humanities in Medicine* 3 (2008): 5; I.H. Kerridge et al., 'Death, Dying and Donation: Organ Transplantation and the Diagnosis of Death', *Journal of Medical Ethics* 28 (2002): 89.

been successfully adopted in a number of jurisdictions and assesses how their practices could be revised into a contextually appropriate model to be adopted in the UK, before bringing the discussion to a close in Part 4.

2. The Judicial Birth of Death

From a medical perspective, death in the UK has been equated with the notion of brainstem death since the 1970s. According to the statement issued by the Conference of Medical Royal Colleges in 1976, '[i]t is agreed that permanent functional death of the brainstem constitutes brain death and that once this [has] occurred further artificial support is fruitless and should be withdrawn'.⁴ By declaring brainstem death as the yardstick by which the withdrawal of artificial support could be justified, the implication is therefore made that this constitutes human death. This was later confirmed in 1979 in an addendum to the 1976 report.⁵ Today, the concept of brainstem death is defined clinically as 'the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe'⁶ by the Academy of Medical Royal Colleges. The operating conditions and criteria used to diagnose it are currently embedded within their 2008 Code of Practice for the Diagnosis and Confirmation of Death. The Code specifies that brainstem testing should be conducted by at least two doctors who have been registered for more than five years and are competent in the conduct and interpretation of brainstem testing. Testing should be carried out together and must be performed on two occasions. Death is only confirmed after the second test has been completed. According to the Royal College of Paediatrics and Child Health, the British Paediatric Association, the Royal College of Physicians and the Department of Health, the criteria are also applicable to infants and children over the age of two months.

4 'Diagnosis of Death: Statement Issued by the Honorary Secretary of the Conference of Medical Royal Colleges and their Faculties in the United Kingdom on 11 October 1976', *Annals of the Royal College of Surgeons of England* 59, no. 2 (1977): 170.

5 Where it was stated that '[b]rain death represents the stage at which a patient becomes truly dead because by then all functions of the brain have permanently and irreversibly ceased'; see 'Diagnosis of Death: Memorandum Issued by the Honorary Secretary of the Conference of Medical Royal Colleges and their Faculties in the United Kingdom on 15 January 1979', *British Medical Journal* 1 (1979): 332. This was influenced by a similar medical development in the US where brain death, defined as the irreversible cessation of all functions of the entire brain including the brainstem, was equated with death; see H. Beecher, 'A Definition of Irreversible Coma, Report of the Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death', *Journal of the American Medical Association* 205, no. 6 (1968): 85.

6 Academy of Medical Royal Colleges, Code of Practice for the Diagnosis and Confirmation of Death (2008), 11.

Although the Code carries considerable moral authority, it has no legal or quasi-legal status. However, because of the presence of a high degree of consensus among the professional bodies, it has always been deemed that the medical criteria for ascertaining death are settled. There does not therefore seem to be a necessity for any supporting legislation which defines death.⁷ Neither have the courts traditionally been called upon to determine the issue of when someone was dead.⁸ However, the advent of the mechanical ventilator and intensive care medicine has resulted in a small number of cases coming before the courts, and their endorsement of the medical standard in these cases has gained brainstem death its current status as the legal determinant of death.

One of the earliest decisions which touched on the issue was the jointly heard cases of *R v. Malcherek* and *R v. Steel*.⁹ The court was here confronted with two similar situations where the defendants violently attacked their victims. In both cases, the victims were placed on mechanical ventilators which were eventually switched off by their doctors when brainstem death was established. In deciding whether the respective chains of causation between the attacks and the deaths were broken by the doctors' acts, the court opined that:

'[w]here a medical practitioner adopting methods which are generally accepted comes bona fide and conscientiously to the conclusion that the patient is for practical purposes dead, and that such vital functions as exist – for example, circulation – are being maintained solely by mechanical means, and therefore discontinues treatment, that does not prevent the person who inflicted the initial injury from being responsible for the victim's death (per Lord Lane at 697)'.

This statement seemed to endorse three things. First, the medical profession's definition of death. Secondly, that this is the applicable determinant of death for the purpose of the law of homicide. Thirdly, the methods used by the medical profession to reach the diagnosis, i.e. the criteria recommended by the Medical Royal Colleges.

Support for the medical view that brainstem death is synonymous with death is also evident in civil law. In *Re A (A Minor)*,¹⁰ a very young boy who was put

⁷ D. Inwald, I. Jakobovits & A. Petros, 'Brain Stem Death: Managing Care when Accepted Medical Guidelines and Religious Beliefs are in Conflict', *Journal of Medical Ethics* 320 (2000): 1266 at 1267.

⁸ I. Kennedy & A. Grubb, *Medical Law* (London: Butterworths, 2000), 2210. Although there was a small number of early cases, these were concerned more with conflicting claims over the cause of death in murder trials; see for example *R v. Harding (Ellen)* (1936) 25 Cr. App. R. 190; *R v. Lomas* [1969] 1 WLR 306.

⁹ *R v. Malcherek*; *R v. Steel* [1981] 1 WLR 690, CA.

¹⁰ [1992] 3 Med. L.R. 303.

on a ventilator when he was admitted into the intensive care unit of a hospital was diagnosed by doctors as brainstem dead. In view of this diagnosis, the judge said that he had no hesitation in holding that the child was dead for all legal and medical purposes, and that the hospital would not be acting against the law if it disconnected the child from the ventilator. An even clearer judicial endorsement of brainstem death came from the House of Lords in *Airedale NHS Trust v. Bland*.¹¹ In this high profile case concerning the legality of the discontinuation of all life-sustaining treatment and medical support from a patient in a persistent vegetative state (PVS), it was held that since such patients still have functioning brainstems, they are still alive. According to Lord Keith, ‘in the eyes of the medical world and of the law a person is not clinically dead so long as the brainstem retains its function’ (at p. 856). Concurring, Lord Goff asserted that ‘death occurs when the brain, and in particular the brainstem, has been destroyed’ (at 863). Discontinuation of life-sustaining treatment from PVS patients would therefore need to proceed on grounds other than that they are dead. Taken together, the decisions in *Re A (A Minor)* and *Airedale* illustrated the courts’ approval of the medical profession’s definition of death and the procedure followed to determine brainstem death.

Through these pronouncements in the criminal and civil law contexts, the judiciary therefore incorporated the Royal Medical Colleges’ definition of death and diagnostic criteria into the common law. However, these cases also show that when the courts approved the medical standard of death, the decisions were reached on an ad hoc basis. In other words, judges were merely responding to the dilemmas presented before them. The conceptual and policy issues at stake were consequently not at the forefront of their minds and were effectively excluded from courtroom debate. Indeed, given how judges are frequently reminded to address only issues which are associated with the factual context which requires their determination, they are not expected or encouraged to exceed this remit.¹² As Lord Lane put it bluntly in *Rv. Malcherek; Rv. Steel*, ‘[i]t is no part of the task of this court to inquire whether the criteria, the Royal Medical Colleges’ confirmatory tests, are a satisfactory code of practice’ (at 695).

Yet on this particular matter, those endorsements have far-reaching social and legal implications. First, upon a diagnosis of brainstem death, patients cease to be persons in the eyes of the law. It would be lawful to withdraw vent-

¹¹ [1993] A.C. 789. See also I. Kennedy, ‘Definition of Death: *Re A (A Minor)*’, *Medical Law Review* 1 (1993): 98 at 99.

¹² See e.g. *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112 per Lord Bridge at 193–194; *Burke v. General Medical Council* [2005] EWCA Civ 1003 per Lord Phillips MR at para. 21; S. Jasanoff & D. Nelkin, ‘Science, Technology and the Limits of Judicial Competence’, *Science* 214, no. 4526 (1981): 1211.

ilation and other life-sustaining treatments from them without recourse to the courts.¹³ Secondly, it allows those patients to be treated as cadavers. This legal definition allows their organs to be maintained for harvesting, and removed while their heartbeat and circulation are preserved by mechanical ventilation and where to all outward appearances they do not look like a corpse.¹⁴ It did not take long before the brain-based criteria for defining death led to an ever-increasing number of cadaveric organs for purposes of transplantation, so much so that 'heart-beating' donors are now the principal source of organs for transplantation in the UK.¹⁵

But is it right that a matter as paramount as the definition of death, with all its grave implications, should be defined purely in medical terms and not be subjected to a public debate and consensus? Further, even if brainstem death is accepted as a definition of death, is it right that it should be the only definition recognised by the law, which is then superimposed upon those who subscribe to a different understanding of death? We will now look at the viewpoints of a few religious groups which object to this method of determining death, and consider what lessons could be assembled from jurisdictions which accommodate the preferences of those who are opposed to a brain-based definition.

3. Faith-based Objections to Brainstem Death

From a religious perspective, the permissibility of organ donation itself is now hardly in contention. Many mainstream religions now deem this as a noble act of charity whose life-saving potential is not easily matched by other deeds.¹⁶ However, while organ and tissue donation from live

¹³ N.S. Peart et al., 'Maintaining a Pregnancy Following Loss of Capacity', *Medical Law Review* 8 (2000): 275 at 283; B. Jennett, 'Brain Stem Death Defines Death in Law', *British Medical Journal* 318 (1999): 1755; J.M.A. Swinburn et al., 'To Whom is Our Duty of Care?', *British Medical Journal* 318 (1999): 1753.

¹⁴ In addition to being pink and warm, the body of brainstem dead patients who continue to be artificially ventilated can perform many of the functions of a living person like eliminating waste, wound healing, fighting of infections and even the successful gestation of a foetus; see J.M. Dubois, 'Is Organ Procurement causing the Death of Patients?', *Issues in Law and Medicine* 18, no. 1 (2002): 21; N.S. Peart, 'Maintaining a Pregnancy' (note 13): 275; D. Sperling, 'Maternal Brain Death', *American Journal of Law and Medicine* 30, no. 4 (2004): 453; R. Fletcher, M. Fox & J. McCandless, 'Legal Embodiment: Analysing the Body of Healthcare Law', *Medical Law Review* (2008): 321 at 339.

¹⁵ L.L. Bailey, 'Organ Transplantation: A Paradigm of Medical Progress', *Hastings Center Report* 20, vol. 1 (1990): 24; S. Ridley, 'UK Guidance' (note 2): 592.

¹⁶ To Christians, organs donated to others are truly 'gifts of life'; see F.D. Yates, 'Donor After Cardiac Death: What is the Christian's Response?', <http://cbhd.org/content/donor-after-cardiac-death-what-christian-s-response> (2 February 2007). Muslims often refer to this verse in the Qur'an when discussing organ donation: 'whosoever saves a life, it shall be as if he has given life to all mankind' (Surah Al-Ma'idah, verse 32). Similarly, the *Mishnah* (Jewish oral law) teaches that 'to sustain a single human soul is equivalent to sustaining an entire world';

donors and from donors who are clearly dead do not give rise to much controversy, the same is not always the case when it comes to the removal of vital organs from brain-injured patients who are still breathing via mechanical ventilators. This part of the discussion considers the objections which have been asserted by the adherents of the Christian, Islam and Jewish faith traditions against equating brainstem death with the death of the person.¹⁷ In advocating for their standpoints on this matter to be legally recognised and protected, we will reflect on the lessons that can be learned from jurisdictions which already adopt a pluralistic approach to the definition of death.

3.1 Religious Objections

Christianity

Christians from the Catholic denomination have expressed strong opposition to the idea that death of the brainstem is synonymous with human death. Instead, death is said to occur at the point when the soul leaves the body. Since the human soul is believed to be, in and of itself, the form of the human body, this is understood to take place when the body dies. Human death, on this view, therefore consists of the death of the body rather than the absence of a capacity or function.¹⁸ The latter is deemed as nothing more than a stipulated point in the dying process, and is certainly not a signifier that the soul has left the body. As expressed by Pope Pius XII: ‘human life continues for as long as its vital functions – distinguished from the simple life of organs – manifest themselves spontaneously or even with the help of artificial processes’.¹⁹

Sanhedrin 4:5 as cited in S.J. Werber, ‘Ancient Answers to Modern Questions: Death, Dying, and Organ Transplants – A Jewish Law Perspective’, *Journal of Law and Health* 11, no. 1-2 (1996): 13.

¹⁷ It is nevertheless important to note that there is a lack of unified interpretations both within and across religions. Some within these faith traditions do accept brainstem death as constituting the end of life for purposes of organ transplantation, see for example M. Seeley, ‘Brain Stem Death and Organ Transplantation’, *Catholic Medical Quarterly* 62, no. 3 (2012): 44; Working Group on the Determination of Brain Death and its Relationship to Human Death, *Scripta Varia* 83 (Vatican City: Pontifical Academy of Sciences, 1992); Pontifical Council for Pastoral Assistance, *Charter for Health* (Boston: St Paul Books and Media, 1994); ‘UK’s Muslim Law Council Approves Organ Transplants’, *Journal of Medical Ethics* 22 (1996): 99; F.A. Khan, ‘Religious Teachings and Reflections on Advance Directive: Religious Values and Legal Dilemmas in Bioethics; An Islamic Perspective’, *Fordham Urban Law Journal* 30, no. 1 (2002): 267; D. Michaeli, ‘Jews Accept Brain Stem Death’, *British Medical Journal* 319 (1999): 1367; M. Tendler, ‘A Matter of Life and Death – Revisited’, *The Jewish Observer*, 11 October 1991.

¹⁸ D.A. Jones, ‘Nagging Doubts about Brain Death’, *Catholic Medical Quarterly* (1995); Yates, ‘Donor after Cardiac Death’ (note 16).

¹⁹ Pius XII; *Acta Apostolicae Sedis* 49 (1957): 1027–1033, English translation in: *The Pope Speaks* 4 (1958): 393–398. See also P.A. Byrne, S. O’Reilly & P.M. Quay, ‘Brain Death – An Opposing Viewpoint’, *Journal of the American Medical Association* 242 (1979): 1985; S.N. Nelson, ‘“The Least of These”: A Christian Moral Appraisal of Vital Organ Procurement from “Brain-dead” Patients’, *Ethics and Medicine* 20, no. 1 (2004): 7.

He thus contended that vital functions indicate the presence of life, even when artificially maintained. Brainstem dead patients who are maintained on a ventilator are therefore not considered to be morally different from other vulnerable human persons. They have a right not to have the ventilator turned off before asystole. Further, any effort to retrieve their vital organs is deemed as a pre-mortal surgical procedure upon a paralysed patient. Inasmuch as this constitutes the intentional killing of innocent human beings, it is condemned as immoral and should be rejected.²⁰

Islam

Muslims similarly believe that the human being is composed of spiritual soul and material body. The soul is characterised as the entity which moves, and maintains its active relation to, the human body via breathing.²¹ According to the Qur'an, '[e]very soul shall have a taste of death' and the Almighty 'takes the souls (of men) at death.'²² Human death therefore refers to the end of physical life as demarcated by the departure of the soul from the body. However, neither the Qur'an nor the Traditions of the Prophet clearly identify the exact moment when the removal and complete separation of this entity from the whole body takes place. Some Muslim scholars have suggested that since the aliment of the soul is air, it is the cessation of breathing which marks the soul's departure from the body.²³ Thus even if circulation and respiration were rendered possible only with the aid of artificial ventilation, a patient who continues to breathe is accepted as alive. A ventilator-dependent person who is diagnosed with brainstem death is merely dying but not dead, since doubts linger over whether the soul has completely abandoned the body at this stage. If vital organs are procured, it is deemed that these are technically taken from those who are still alive. Not only would this be painful to them, it is the surgery which ends the patient's life. Since Islam does not allow anyone to be

²⁰ D. Evans, 'Brain Stem Death and Organ Transplantation', *Catholic Medical Quarterly* 62, no. 2 (2012): 15.

²¹ A. Bedir & S. Aksoy, 'Brain Death Revisited: It Is Not "Complete Death" According to Islamic Sources', *Journal of Medical Ethics* 37 (2011): 290 at 290–291; W.S. Wan Abdullah, 'Ibn Sina and Abu Al-Barakat al-Baghdadi on the Origination of the Soul', *Islam and Science* 5, no. 2 (2007): 151; I.M. Lapidus, 'The Meaning of Death', in *Facing Death: Where Culture, Religion, and Medicine Meets*, ed. H. Spiro et al., (New Haven: Yale University Press, 1996), 149.

²² Surah Al-Imran verse 185 and Surah Al-Zumar verse 42 respectively. See also A.Y. Ali, *The Meaning of the Holy Qur'an* (Maryland: Amana Publications, 1989), 1192; A. Sachedina, 'Brain Death in Islamic Jurisprudence', <http://people.virginia.edu/~aas/article/article6.htm>; F.A. Khan, 'The Definition of Death in Islam: Can Brain Death Be Used as a Criteria of Death in Islam?' *Journal of the Islamic Medical Association of North America* 18 (1986): 18 at 19.

²³ A. Bedir & S. Aksoy, 'Brain Death Revisited' (note 21), 290–293; M.Y. Rady & J.L. Verheijde, 'Brain Death Is Not "Complete Death" in Islam: A Global Call for Revising the Legal Definition of Death in Islam', *Journal of Medical Ethics* 37 (2011): 290; M. Mousawi et al., 'Views of Muslim Scholars on Organ Donation and Brain Death', *Transplantation Proceedings* 29 (1997): 3217.

sacrificed for the sake of another, someone who has been diagnosed as brainstem dead cannot be sacrificed just to aid another person who is in need of an organ. The procurement of vital organs can only take place when the donor is fully dead. This point is signified by the cessation of respiration, which is generally accepted as the determinant evidence that the soul has left the body.

Judaism

Brainstem death is likewise not recognised by Orthodox Jews as the determinant of human death. Rather, it is heartbeat or respiration which are generally recognised as the signifier of life and whose cessation represents the moment of death. It has been stressed, for instance, that ‘one whose heart still beats still lives’²⁴ and that this is so irrespective of the irreversible cessation of brain function. When addressing the obligation to save lives, the Talmud gave the example of a person who was trapped under a collapsed building and instructed that in order to save his life, the debris must be removed until the nose is reached so that respiration can be determined. It indicated that the person, ‘in whose nostrils was the breath of the spirit of life’,²⁵ is considered dead when there is no respiration at the nostrils. This viewpoint was re-emphasized in recent times by the Chief Rabbi Lord Jonathan Sacks and his rabbinical court, the London Beth Din, that cardiorespiratory death is definitive in classical Jewish law.²⁶ Death is recognised only when there is neither breathing nor cardiac pulsation, whether these are spontaneous or artificially maintained. To withdraw ventilation and life support treatment from brainstem patients is therefore deemed as an act of murder. It follows from this that the procurement of vital organs from such patients is ‘absolutely not permissible’²⁷ since it is said to be equivalent to the taking of the life of one person to save another, thereby using the person as a means rather than as an end. Hence cadaveric

²⁴ D. Zweibel, ‘Accommodating Religious Objections to Brain Death: Legal Considerations’, *Journal of Halacha and Contemporary Society* XVII (1989): 49 as quoted in R.S. Olick, ‘Brain Death, Religious Freedom, and Public Policy: New Jersey’s Landmark Legislative Initiative’, *Kennedy Institute of Ethics Journal* 1(4) (1991): 275 at 277. See also D. Inwald, I. Jakobovits & A. Petros, ‘Brain Stem Death’ (note 7): 1267; S.J. Werber, ‘Ancient Answers to Modern Questions: Death, Dying, Organ Transplants – A Jewish Law Perspective’, *Journal of Law and Health* 11(1–2) (1996): 13.

²⁵ Babylonian Talmud Yoma 85a, citing Genesis 7:22; cited in M.A. Grodin, ‘Religious Exemptions: Brain Death and Jewish Law’, *Journal of Church and State* (1994): 357. See also Y. Breitowitz, ‘The Brain Death Controversy in Jewish Law’, www.hods.org/pdf/Breitowitz%20Brain%20Death%20Controversy.pdf.

²⁶ R. Butt, ‘Doctors Criticise Chief Rabbi’s Edict Against Donor Cards’, *The Guardian*, 11 January 2011; J. Sacks, ‘Organ Donor Cards Are Not Incompatible with Jewish Law’, *The Guardian*, 14 January 2011.

²⁷ S.Z. Auerbach & Y.S. Elyashiv, ‘Letter to Agudath Israel 18th Menachem Av. 5751’ (29 July 1991) as cited in ‘A Matter of Life and Death – Revisited’, *The Jewish Observer* (October 1991), cited in M.A. Grodin, ‘Religious Exemptions’ (note 25), 366.

organ donation by an Orthodox Jew may usually only take place at the point of cardiorespiratory failure i.e. when neither breathing nor cardiac pulsation can be detected.

A determination of death on the basis of neurological criteria therefore contravenes the theological definition of death in some segments of the Abrahamic faith traditions. Meanwhile, the public has thus far only been encouraged to donate organs, without at the same time acquiring an understanding of when death occurs. More to the point, it has never been asked whether it agrees that brainstem death equates human death. Yet an ethically-sound organ procurement policy should not only give consideration to the needs of organ recipients, but also to the dignity and interests of donors.²⁸ Thus respect for autonomy, which is often emphasised in the medical context, should also extend to giving individuals the right to refuse a brain-centred definition if this goes against their beliefs.²⁹ It follows that there needs to be wider acknowledgement that an issue as significant as when one's life ends is not merely a medical issue. Rather, its significance is such that the legal definition of death needs to be forged through the parliamentary process, where all faith-based groups could be consulted and heard through the green and white papers process and parliamentary debates. For this, English law could be guided by the experiences of jurisdictions that have adopted a pluralistic approach to the definition of death. We will now look at the legal frameworks that have been set up in Japan, Israel and the USA.

3.2 Lessons from Other Jurisdictions

Japan

Historically, Japan has resisted defining death through neurological criteria. In fact it even prohibited transplantation from brain-dead donors following the investigation of Dr Juro Wada, the surgeon who performed the first heart transplant in the country in 1968, for murder after removing the heart of an 18-year-old brain-dead drowning victim and implanting it into another teenager who was dying from a congenital heart disease. He was, although the matter was eventually dropped, accused of removing the heart while the donor was still alive and thereby causing his death. The episode inevitably casts a long

²⁸ A. Bagheri, 'Individual Choice in the Definition of Death', *Journal of Medical Ethics* 33 (2007): 146. See also R.D. Orr & L.B. Genesen, 'Requests for "Inappropriate" Treatment Based on Religious Beliefs', *Journal of Medical Ethics* 23 (1997): 142 at 147.

²⁹ This is compounded by the fact that brain-related death has also courted objections from a philosophical perspective. See e.g. Miller & Truog, *Death, Dying* (note 1), 52-79; J.P. Lizza, 'Persons and Death: What's Metaphysically Wrong with our Current Statutory Definition of Death', *Journal of Medicine and Philosophy* 18 (1993) 351; W. Glannon, *Bioethics and the Brain* (New York: Oxford University Press, 2007).

shadow over public faith in vital organ transplantation and the medical profession.³⁰ The strong scepticism derived mainly from the country's religious culture whereby, according to Shinto belief, it is premature and unnatural to declare death while the heart is still beating.³¹ Death is acknowledged only after the cessation of heartbeat. In fact it was not for another three decades, and only after being confronted with numerous cases of Japanese having to travel abroad for vital organs,³² that a law was passed in 1997 which recognised a dual definition of death in Japan.

The Japanese Organ Transplantation Law of 1997 allows individuals to choose the definition of death based on their own views: either brain death or the traditional definition of human death based on the cessation of cardio-respiratory functions. It therefore offers a compromise to those who reject neurological death by allowing them to choose a definition of death which coheres with their own viewpoint. For organ donation on the basis of brain death to take place, the diagnosis of death and the removal of organs can only be carried out under restricted circumstances. There must be a written document declaring the prospective donor's intentions signed by both the prospective donor and the family, expressing 'his intent to agree to donate his organs and agree to be submitted to an authorised brain death declaration, and [that] his family members (spouse, parents, children, grandparents, grandchildren, and live-in family members) did not object to the donation'.³³ This means that the choice must be made in agreement with, rather than independently of, the family. However, family members can change their mind when brain death occurs and are empowered by law to override or refuse the individual's choice of the determinant of death (as well as for organ donation). This reflects the usual Japanese assumption that the family is the decision-making unit for whom the protection of the patient holds far greater importance than the promotion of his or her autonomy. It also indicates that the process of dying is a family and not an individual event in Japan. The patient's body is seen as belonging as much to the family as to the deceased, and the removal of organs from the body without

³⁰ T. Larimer, 'A Change of Heart', *Time*, 15 March 1999; R. Kimura, 'Japan's Dilemma with the Definition of Death', *Kennedy Institute of Ethics Journal* 1, no. 2 (1991): 123; C. Haberman, 'A Transplant Trauma: Is Soul-searching Ending?', *The New York Times*, 10 February 1987.

³¹ J.R. McConnell, 'The Ambiguity about Death in Japan: An Ethical Implication for Organ Procurement', *Journal of Medical Ethics* 25 (1999): 322 at 322.

³² See e.g. The Associated Press, 'Japanese Girl Dies in LA while Awaiting Transplant', *The Register Guard*, 16 April 1997; S. WuDunn, 'In Japan, Use of Dead Has the Living Uneasy', *The New York Times*, 11 May 1997.

³³ Usually on an organ donation decision card but they are also able to make written declarations in health insurance cards and driving licences. See K. Kikuchi & G. Misa, 'Usefulness of Organ Donation Decision Card', *Japanese Journal of Transplantation* 41, no. 4 (2006): 323 and 'The Enactment of the Organ Transplantation Law, and the Revised Organ Transplant Act', www.jotnw.or.jp/english/04.html.

the family's approval is objectionable.³⁴ However, where the deceased had never made known their decision regarding the definition of death and organ transplantation, family members were not allowed to select the use of brain-based criteria for determining death.³⁵ Neither were they allowed to approve the removal of organs, other than kidneys and corneas, for transplantation after the patient had suffered cardiac arrest. This aspect of the law was recently amended in 2009 by the Organ Transplant Act which permits the removal of organs from brain-dead patients who have never made their wishes clear during their lifetime, if family members allow for donation to proceed and where the patients were not known to have registered any objection to organ donation.³⁶

Israel

Like Japan, Israel has long resisted adopting a definition of death which is associated with brain activity. This is owing to general opposition from religious parties and the public, which resulted in a dearth of cadaveric organ donors and a very low number of transplants carried out in the country.³⁷ The Brain Death-Respiratory Law was passed in 2008 to help rectify the situation by allowing death to be determined either when there is brain-respiratory death³⁸ or cardiac-respiratory death. Hence a choice is offered between brain-centred and cardiac-centred definitions. A further safeguard of choice is provided when

³⁴ D. Forster, 'When the Body is Soul: The Proposed Japanese Bill in Organ Transplantations from Brain-dead Donors', *Pacific Rim Law and Policy Journal* 3, no. 1 (1994): 103 at 117; S.O. Long, 'Negotiating the "Good Death": Japanese Ambivalence about New Ways to Die', *Ethnology* 40, no. 4 (2001): 271.

³⁵ The same if the patient has declared against transplantation. In both these circumstances, doctors are not allowed to reach a legal diagnosis of brain death and the patient is considered alive until the heart stops beating; see M. Morioka, 'Reconsidering Brain Death: A Lesson from Japan's Fifteen Years of Experience', *Hastings Center Report* 31, no. 4 (2001): 41; A. Bagheri, 'Criticism of "Brain Death" Policy in Japan', *Kennedy Institute of Ethics Journal* 13, no. 4 (2003): 359 at 366.

³⁶ For discussion, see M. Ida, 'The Concept of Death in the Revised Organ Transplant Law in Japan', *Nihon Rinsho* 68, no. 12 (2010): 2223; S. Nagahiro, 'Revised Act on Organ Transplantation from Neurosurgeon's Viewpoint', *Brain Nerve* 62, no. 6 (2010): 575; N. Fukushima, 'Revised Organ Transplant Act and Transplant Surgeons', *Japan Medical Association Journal* 54, no. 6 (2011): 387.

³⁷ T. Ashkenazi & M. Klein, 'Predicting Willingness to Donate Organs According to the Demographic Characteristics of the Deceased's Family', *Progress in Transplantation* 22, no. 3 (2012): 304; A.B. Jotkowitz & S. Glick, 'Navigating the Chasm between Religious and Secular Perspectives in Modern Bioethics', *Journal of Medical Ethics* 35 (2009): 359.

³⁸ This is determined, according to s.3 of the Act, by two physicians in line with the following criteria: the medical cause of the cessation of brain function is clearly known; that there is clinical evidence of the absence of independent respiration; there is clinical evidence of complete and irreversible cessation of whole brain function including brainstem function; a confirmatory examination has proved the complete and irreversible loss of whole brain function including brainstem function; and that medical conditions that could cause errors in the examinations listed above have been ruled out.

it comes to the former. Section 8 of the Act states that even where brain-respiratory death has been determined, and it was discovered that this determination was incompatible with the patient's religious beliefs according to information supplied by family members, the patient should not be disconnected from the ventilator and that supportive treatment should be continued until the patient's heart stops beating. Further, in order to accommodate the religious viewpoint that death may only be determined when spontaneous breathing function ceases irreversibly, the law specifies that brain death has to be accompanied by the cessation of the ability to breathe independently (which is controlled by the brainstem) rather than recognising the possibility of brain death per se as a definition of death.³⁹ But the crux of the matter is that Israel does not just adopt one definition of death. A choice is offered to individuals as to how they define death.

United States: New Jersey and New York

Even in the United States, where whole brain death is uniformly accepted across the country as the legal standard of death,⁴⁰ at least two states – namely New York and New Jersey – have passed laws aiming to protect the religious beliefs or moral convictions of their diverse and pluralistic population. Both states, while recognising whole brain death as a legal standard for declaring death, have felt it important to respect the wishes of those who would like to opt out of being determined dead on the basis of neurological death. In New York, all hospitals are placed under a legal obligation to develop a written policy and procedure for the 'reasonable accommodation' of their patients' religious or moral objection to the determination of death based on brain-centred criteria.⁴¹ The objection could be expressed either by the individual, or by the family. If the latter, this would be based on the values and wishes of the individual rather than those of the family. When an assertion of a religious exemption is followed by a request for accommodation, the hospital must follow standard cardio-respiratory criteria alone. Until this is done, the patient, even

³⁹ J. Cohen et al., 'Brain Death Determination in Israel: The First Two Years Experience Following Changes to the Brain Death Law – Opportunities and Challenges', *American Journal of Transplantation* 12 (2012): 2514; A.B. Jotkowitz & S. Glick, 'Navigating the Chasm' (note 37), 360.

⁴⁰ Defined as the irreversible cessation of all functions of the entire brain, including the brain stem; see the Uniform Determination of Death Act (UDDA) 1990. The UDDA nevertheless provides an alternative definition which signifies that a patient is also dead when they sustained an irreversible cessation of circulatory and respiratory functions.

⁴¹ New York Codes Rules and Regulations (1987), Title 10, s. 400-16.

if brain dead, would still be considered alive and as such, entitled to continuing health coverage.⁴²

New Jersey went a step further by giving recognition to a religious exemption (a conscience clause) in statutory law. According to section 6 of its Declaration of Death Act 1991: '[t]he death of an individual shall not be declared upon the basis of neurological criteria ... when such a declaration should violate [the individual's] personal religious beliefs or moral convictions ... and when that fact has been communicated to, or should, reasonably be known by, the licensed physician authorised to declare death.'⁴³ This places a duty on doctors to make reasonable efforts to ascertain whether a declaration of brain death would violate the religious or moral beliefs of the individual. This may entail reviewing the patient's medical records or investigating whether an advance directive has been made. The responsibility for providing the relevant information rests with the individual or the individual's family, friends, personal doctor or religious leader. As in New York, the right of conscience belongs to the individual and not to the family. The latter are not, therefore, being asked for their own consent regarding the declaration of the individual's death. Nor are they legally allowed to substitute their own beliefs for the individual's.⁴⁴ When the exemption is invoked on the basis of the individual's beliefs, death shall be declared, and the time of death fixed, solely on the basis of traditional cardio-respiratory criteria. Cardio-respiratory support is to be continued until this occurs and is not to be brought to an end exclusively on the ground of the individual's neurological status. In other words, the individual would, as a legal matter, still be considered alive even if neurological death has been confirmed. The law also requires that insurance coverage should continue during this period of accommodation and that no discrimination is allowed for the exercise of religious beliefs. It is nevertheless important to note that the Act does not allow individuals to select any novel or idiosyncratic standard for the determination of death. Only those with conscientious beliefs are permitted to reject the neurological criteria and for them, only the irreversible cessation of circulatory and respiratory functions is recognised as the alternative determinant of death.

As the experiences of these jurisdictions show, it is entirely possible to accommodate the preferences of those with a religious objection to being declared dead on the basis of neurological criteria. English law could similarly offer a

⁴² For general discussion, see R.S. Olick, E.A. Braun & J. Potash, 'Accommodating Religious and Moral Objections to Neurological Death', *Journal of Clinical Ethics* 20, no. 2 (2009): 183; M.A. Grodin, 'Religious Exemptions' (note 25); 368-369.

⁴³ New Jersey Declaration of Death Act 1991, Title 26.

⁴⁴ For general discussion, see R.S. Olick, 'Brain Death, (note 24): 275; M.A. Grodin, 'Religious Exemptions' (note 25), 369-370.

choice between brain- stem death and one or more options; or provide a conscience clause to enable such objections to be legally protected. This needs to be preceded by rigorous debate over what other alternatives, if any apart from cardio-respiratory criteria, the public would be willing to accommodate. Should the choice be limited to objections made on religious grounds lest the option be left too wide open, with people asking for various kinds of definitions of death? Also of relevance is a decision over which religious beliefs the accommodation should be extended to; and whether it applies also to children and those who have always been mentally incompetent. In addition, although an individual-based rather than a family-based decision would be more appropriate for the British context, the role played by the family should not be discounted. With the current policy on cadaveric organ donation still expecting doctors to consult the deceased's relatives, irrespective of the patient's previously stated wish to donate his organs after death, in practice family members could thwart the patient's decision. This is notwithstanding the Human Tissue Authority (HTA)'s suggestion that it should be made clear to them that they do not have the legal right to veto or overrule the deceased person's wishes (paragraph 99 of the HTA's Code of Practice). The public needs to decide whether this policy should persist and extend to its viewpoint on death; or whether it is only the individual's understanding of death, as documented in an advance directive or from information gathered from those who know the person well, which should be respected. Such engagement of the democratic process where all voices within the society are represented would be superior to the current judicial endorsement which was reached on an ad hoc case law basis.

In calling for a pluralistic approach to the definition of death, it is necessary to acknowledge that a definition of death holds implications not only for organ donation and the withdrawal of life sustaining medical treatment, but is also relevant to issues like death rituals, property, insurance and other legal arrangements. All these therefore underline the significance of a uniform standard of death.⁴⁵ Besides, it may even be deemed undesirable that two patients in identical physiological states would be diagnosed as dead or alive depending on whether they belong to a faith community. However, as the experiences of New York and New Jersey in particular have demonstrated, such a practice has not courted public disapproval nor unease. Rather, there seems to be acceptance that the societal need for uniformity in the application of a specific standard for the affirmation of death should not be so absolute as to rule out reasonable efforts to accommodate the religious beliefs of some of its members.⁴⁶ Death

⁴⁵ R.S. Olick, E.A. Braun & J. Potash, 'Accommodating Religious' (note 42), 183.

⁴⁶ M.A. Grodin, 'Religious Exemptions' (note 25); Pontifical Council for Pastoral Assistance, Charter for Health, 371.

and dying are concepts which are owned by all religions, communities and individuals. Inasmuch as they are intricately linked to the issue of organ donation, it is important to remember that the success of the transplantation system depends on the final decision of people who are unrelated to the health system.⁴⁷ Attention should therefore be given to the factors that condition personal decisions in this matter, of which spiritual beliefs about death are undoubtedly a consideration.

4. Conclusion

As the vital organs of individuals who are unequivocally dead are generally unsuitable for transplantation purposes, it has become important for such organs to be removed from patients whose bodily organs are still fully functional.⁴⁸ However, because of the operation of the DDR, it is imperative that the organs are procured only after the patient has been declared dead. In 1976, death was redefined on the basis of neurological criteria. Since then, brainstem death has been the medico-legal standard for death which underpins transplant practice in the UK. Following a diagnosis of brainstem death, vital organs can be removed, even if the patient's respiration and cardiac functions are still maintained by the ventilator. However, a brain-based definition of death is ultimately an artefact of technology, as without machines to sustain the breathing and heartbeat of severely brain-injured patients, it would not exist as a diagnostic category.⁴⁹ Thus despite its general acceptance in medicine, this modern definition is not one which is congruent with some faith groups' traditional understanding of death.

As discussed, it needs to be acknowledged that the definition of death is not the sole preserve of medicine. In a multi-faith society such as the UK, it is important that religious worldviews on death be given due consideration and that any criteria used to determine death should be subjected to the democratic process. It has also been demonstrated that a pluralistic approach has been

⁴⁷ M.M. Harrington, 'The Thin Flat Line: Redefining Who is Legally Dead in Organ Donation after Cardiac Death', *Issues in Law and Medicine* 25, no. 2 (2009): 95 at 103; I.H. Kerridge et al., 'Death, Dying' (note 3), 93; T. Long, M. Sque & J. Addington-Hall, 'What Does a Diagnosis of Brain Death Mean to Family Members Approached about Organ Donation? A Review of the Literature', *Progress in Transplantation* 18, no. 2 (2008): 118; J.S. Lopez et al., 'Factors Related to Attitudes toward Organ Donation after Death in the Immigrant Population in Spain', *Clinical Transplantation* 26 (2012): 200.

⁴⁸ D.W. Evans, 'Seeking an Ethical and Legal Way of Procuring Transplantable Organs from the Dying without Further Attempts to Redefine Human Death', *Philosophy, Ethics, and Humanities in Medicine* 2 (2007): 11-12.

⁴⁹ L.A. Siminoff, C. Burant & S.J. Youngner, 'Death and Organ Procurement: Public Beliefs and Attitudes', *Kennedy Institute of Ethics Journal* 14, no. 3 (2004): 217 at 218.

implemented successfully in other jurisdictions. Their experience could guide public debate in the UK and help carve a legislative framework which is cognisant of the religious sensitivities of its population. Although it is not clear how far the current definition of death has been an impediment to organ donation, or indeed how far a pluralistic approach could improve donation rates, studies have shown that among the leading causes for refusing to allow the removal of one's brainstem dead relatives' organs, is a lack of understanding of brain-related death.⁵⁰ Thus it would not be too far-fetched to suggest that a pluralistic approach to the definition of death, which allows death to be pronounced in accordance with how one's religious community understands the concept, could in time lead to increased willingness to donate one's own and one's relatives' organs, even if only as non-heart-beating donors. In the words of the Chief Rabbi, '[a]s soon as this is implemented I will carry [a donor] card myself'.⁵¹

⁵⁰ I.H. Kerridge et al., 'Death, Dying' (note 3), 89.

⁵¹ J. Sacks, 'Organ Donor Cards' (note 26).