

HEALTH LAW

Reexamining the Flawed Legal Basis of the “Dead Donor Rule” as a Foundation for Organ Donation Policy

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Abstract

The legal basis of what’s known as the “dead donor rule” (DDR), which requires that donors must be dead according to legal criteria, is rooted in physicians’ fears of civil and criminal liability for participating in organ retrieval and donation. This article suggests that one reason to revisit the DDR is to help illuminate possible legal ways to retrieve and donate organs. Specifically, this article considers one of these: medically justifiable homicide, which is legally and ethically distinct from murder and wrongful death.

Origins

Organ donation in modern medicine is governed by a straightforward ethical norm: that before the retrieval of any vital organs (eg, the heart), a donor must first be dead, ie, “patients must be declared dead before the removal of any vital organs for transplantation,”¹ a requirement known as the dead donor rule (DDR). While this mandate is simple and seems logical on its face, in practice the DDR is a problematic doctrine in need of reform. In recent years, scholars have noted the quandaries that the rule has created: it has expanded the definition of biological death (eg, by inclusion of “brain death”)² and has precluded some terminal patients (eg, those with neurodegenerative diseases like amyotrophic lateral sclerosis, or ALS) from donating their organs.³

The weakness of the DDR stems from its presumed ethical and legal justifications and the key problems they attempt to solve. One ethical justification is designed to protect vulnerable people from being “sacrificed” or “killed” for their organs.⁴ An additional ethical rationale, which reflects the perspective of physicians, is that the Hippocratic Oath forbids physicians from harming or killing their patients; hence, the DDR acts as a safeguard to ensure that ethical medical practice prohibits the deliberate killing of patients.⁴ The legal basis—that dead donors must be legally dead—is equally important and compelling in understanding the rule’s rationale. The legal basis, which is meant to protect physicians, is rooted in organ transplant physicians’ fear of being held civilly and criminally liable for killing a patient. By better understanding the legal basis of the DDR and its implications, alternative solutions can be explored that might enable physicians to legally participate in organ donation outside of the DDR.

Legal Basis

Physicians' anxiety about being prosecuted for being involved in the organ procurement process was evident in the 1970s, when the legality of organ procurement from brain-dead patients—ie, those patients with an “irreversible loss of all functions of the brain, including the brain stem”⁵—was at the forefront of medicolegal discussions. As Roger Leng notes, “[t]he real crux of the problem lies with the responsibilities and potential liabilities of the medical profession,” because transplant surgeons are in a “legal vacuum” and are “unsure” whether the actions they take (ie, procurement of organs from a brain-dead patient) are “risking criminal and civil liability.”⁶ This anxiety was a response to the fact that brain death was an accepted medical definition of death but was not yet a recognized legal definition of death in most jurisdictions. Additionally, when legal issues of organ donation were first being debated in the 1960s, the French National Council of the Order of Physicians noted the risk of homicide that physicians procuring organs faced and opined that “declaring first that the subject [the potential organ donor] is dead” is preferable “from a legal point of view, because the death is declared before organ procurement,” thus eliminating legal risk.⁷

Fear of legal liability is a valid concern for any physician involved in the withdrawal of life-sustaining measures in patients who are in a chronic **state of unconsciousness** (eg, comatose state, persistent vegetative state, brain dead), although the risk of legal liability is particularly heightened for transplant surgeons. For example, in the famed Karen Quinlan case (1976), some physicians rejected participating in any withdrawal of life-sustaining measures for Quinlan, as she was in a vegetative state and not brain dead (ie, Quinlan did not suffer “total brain death”—cerebrum plus brain stem—but “cerebral death”), because they were fearful of criminal and civil liability for withdrawing life-sustaining treatment from a patient who, by all known criteria, biological or legal, was deemed living.⁸ However, physicians who remove the life-sustaining measures have a possible legal defense in that their withdrawing treatment is an “omission” and not a “positive act,” and “omission to act can be the basis for homicide liability only where there is a clear duty to act.”⁹ By contrast, transplant surgeons have to **proceed with extreme caution**, as their interventions are a “positive act” akin to a “surgical assault”; if brain-dead patients are deemed legally alive, “there is little a transplant surgeon can do to avoid possible criminal liability short of waiting until the donor’s plug had been pulled and the heart has stopped,”⁹ ie, waiting until the donor was determined legally dead by common law cardiopulmonary death. Therefore, the DDR solved an immediate conundrum confronting worried physicians: simply deem brain-dead donors as also legally dead. Then any organ procurement process involving such donors cannot be the cause of death; any criminal (eg, murder, manslaughter) or civil (eg, wrongful death, malpractice) claims are functionally impossible. However, as noted earlier, the simplicity of this rule creates other problems.

Quandaries

There is a need to reexamine the DDR and its foundation, as the ethical norm itself, while attempting to safeguard vulnerable people and protect physicians, creates 2 notable problems: (1) it shifts the definition of death; and (2) it does not allow some terminally ill patients who wish to donate their organs a way to do so.

Definition of death. The era of multi-organ transplant procurement began in the 1960s and witnessed “competing interests between those who need organs and those who have them.”⁷ Thus, the impetus for brain death understood as both a medical and legal definition of death was the substantial need for organs; indeed, it is still the case that

the “demand for organs far exceeds the supply.”¹⁰ Donation after **circulatory death determination** is not preferred, as this manner of death tends to render “organs unusable”; indeed, nearly one-third of circulatory death donors “end up unable to donate.”³ However, organs from a donor who is brain dead are optimal for donation, as the organs can be procured before “circulatory arrest” and hence have no “anoxic damage.”⁷ In 1968, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death released its report, in which it “defined irreversible coma [with no central nervous system activity] as a new criterion for death,” ie, brain death.¹¹ With what became known as the “Harvard criteria”¹² for determining permanent loss of brain functions, medicine embraced brain death as another medically valid definition of death in addition to cardiorespiratory death and immediately “transformed the nature of transplantation,”³ as a brain-dead patient presented an ideal medically viable organ donor: one deemed medically dead but still possessing organs optimal for donation.

Following changes in technology and medicine’s new definition of death, the law began to follow suit. The traditional common law definition of death was cardiorespiratory, ie, “the cessation of circulatory and respiratory functions as evidenced by the absence of heartbeat, pulse, and respiration.”¹³ But in 1980, a model law known as the Uniform Determination of Death Act (UDDA)¹⁴ was created in response to “modern advances in life-saving technology,”¹⁵ bringing to a head the legal crisis regarding the definition of death. The UDDA codifies the traditional common law basis of death, ie, the “total failure of the cardiorespiratory system,” while additionally codifying the “determination of death based upon irreversible loss of all brain functions,” ie, total brain death as opposed to partial brain death or persistent vegetative state.¹⁵ Either determination of death in the UDDA—cardiorespiratory or brain death—suffices to determine that an individual is legally dead. Most states today have adopted the UDDA and codified some of its language.¹⁶ While “medicolegal variations” between states exist that have caused some confusion and lack of uniformity among jurisdictions,¹⁷ all states “have some form of legal recognition for a neurological standard of death.”¹⁰ Of course, the legal benefit of the states codifying the notion of brain death into law was that it squared the medical and legal definitions of death and mitigated transplant physicians’ risk of criminal or civil liability. As brain death became a legal standard of death along with the established cardiorespiratory standard, it allowed for transplant surgeons to practice without risk of liability.

Although the evolution of the definition of death to include brain death would likely have occurred irrespective of the demand for organs, the inclusion of brain death as a part of death’s definition, in both the medical and legal sense, created a pragmatic shortcut to persuade the public and health professionals that organ procurement was legally and morally safe.⁷ In actuality, determining death has no shortcut; it is a complicated task. As Arthur Caplan argues, death is a “biological process, not an event,” and “biological facts are not sufficient to ensure absolute precision.”¹⁸ Hence, in its essence, death can only be viewed as a “normative concept” that “evolves” over time, reshaped by societal values and the acquisition of knowledge.¹⁸ But in the decades since its acceptance, brain death has become dogma, defended vigorously by academics and professionals alike. This adherence has blunted perception and forward thinking about death, reinforcing brain death as legal death, as the DDR demands. As Robert Truog and Franklin Miller wisely note: “By insisting that the key question was whether brain death is really death, the bioethics community seemed to have missed an opportunity to raise the level of discussion to a much more relevant plane.”²

Limiting terminally ill patients. The other problem created by the DDR is that it precludes organ donation by some terminally ill patients who wish to donate. In her piece examining the evolving ethics of organ donation, Lisa Rosenbaum outlines one such example—a patient with ALS who wanted to donate his organs prior to his death.³ Because the terminal patient (at near death) was still alive, adherence to the DDR precluded him from donating his organs, as the only way his organs could be donated successfully was via “imminent death donation,” whereby a terminal patient (with capacity and consent) donates organs before withdrawal of life-sustaining measures.³ The ALS patient petitioned for “imminent death donation,” but the procedure was vetoed by hospital lawyers who were concerned about legal liability, and the patient ultimately died unable to donate any of his organs, as his organs were unusable at the time of death.³ Recent stories like this one have highlighted a misgiving about the DDR, in that it forecloses other possible organ donation scenarios that might still have an ethically sound basis.

Reexamination

According to Truog and Miller, what the DDR has wrought is the “gerrymandering [of] the definition of death to carefully conform with conditions that are most favorable for transplantation,” which has enabled “unnecessary and unsupportable revisions of the definition of death.”¹ The solution to the quandaries that the DDR raises comes from an examination into the foundations of the norm itself. There is a need to revisit the DDR’s justifications, both ethical and legal. With regard to the ethical justification, Truog and Miller note that it may be “perfectly ethical to remove vital organs for transplantation” from patients deemed dead via neurological criteria (ie, brain dead), but the “reason it is ethical cannot be that we are convinced they are really dead.”¹ Truog and Miller argue that the key to ethical organ procurement is consent of the patient and that “with such consent, there is no harm or wrong done in retrieving vital organs before death.”¹ Robert Sade also focuses on autonomy as key: “The cause of death [ie, whether by the withdrawal of life support or not] is irrelevant because the ethics of self-determination and informed consent that underlies withdrawal of life support are of paramount importance.”¹⁹ Indeed, as Sade argues, the organ procurement system already accounts for valid consent and conflicts of interest; from an ethical standpoint, “the DDR serves no necessary protective purpose.”¹⁹ If, in its essence, the DDR’s ethical justification is unnecessary to safeguard ethical practice, then perhaps the rule’s legal basis may lay claim for why the norm persists.

While the DDR has protected physicians (notably transplant surgeons) from legal liability, it need not be the only way to legally protect them; the law might adapt to allow physicians to perform vital organ donation on a living person. Alternative legal methods can be created, such as a legally permissible or defensible form of homicide for specific situations, like “imminent death donation” of a terminally ill patient or “live donation prior to planned withdrawal” of a brain-dead patient, both implemented in a manner upholding patient autonomy with valid informed consent. Of course, permissible forms of homicide are not unprecedented; the law has carved out valid exceptions, such as common-law self-defense and (in some regions of the world) euthanasia. The DDR functioned as a shortcut to any deeper analysis of whether a homicide is justifiable or not, thus eliminating the question in an effort to embrace a simple solution while also providing maximal protection for the physician. However, the time to reopen legal analysis of medically justifiable homicide is here. Transplant physicians can be protected from criminal and civil liability in ways other than simply first deeming the donor dead; the law can find more creative and pragmatic solutions.

Conclusion

The time has come to reexamine the DDR. While the rule has served a useful purpose—increasing organ donation and ensuring some ethical and legal standards to protect patients and physicians—it is not the only possible option. While some bioethicists maintain that the public is supportive of the DDR (ie, most people don't want to see a person murdered for organs) and fear that its abolishment would diminish organ procurement,²⁰ reality presents a different story. Recent studies have shown that the public is strongly supportive of organ donation “in the scenario of irreversible coma with organ removal causing death.”²⁰ Reflecting on these studies, Nair Collins et al note that while “some scholars have suggested that the idea of abandoning the DDR is out of touch with mainstream opinion, the results of the survey challenge this claim.”²⁰ Forming a new ethical and legal justification for vital organ donation would allow society to dispense with the “legal fiction”² that brain death is the same as the biological death of the entire human being and adopt other legal methods—grounded in the reality of the complexity of and murkiness inherent in death's definition—that may still encourage organ donation and protect physicians.

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