2018

What Makes Killing for Organs Wrong? A Philosophical Defense of the 'Dead Donor' Rule

Adam Omelianchuk
University of South Carolina

What Makes Killing for Organs Wrong?
A Philosophical Defense of the 'Dead Donor' Rule

by

Adam Omelianchuk

Bachelor of Science
University of Northwestern, 2009

Master of Arts
Biola University, 2013

Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Philosophy in

Philosophy

College of Arts and Sciences

University of South Carolina

2018

Accepted by:

Christopher O. Tollefsen, Major Professor

Jennifer A. Frey, Committee Member

George Khushf, Committee Member

Jeffrey P. Bishop, Committee Member

Cheryl L. Addy, Vice Provost and Dean of the Graduate School

Abstract

The purpose of my dissertation is to give a philosophic defense of the so-called "dead donor" rule (DDR) in transplant ethics, something that is sorely lacking in the current literature on the topic. Part of my project is concerned with the rule's correct formulation: What exactly does it forbid? I answer that it is primarily concerned with prohibiting the killing of the donor for his or her organs, and that it need *not* be concerned with requiring that the donor be dead before surgery begins (as important as that might be). What is morally important is that surgery not be the proximate cause of death. Historically, this flows out of the concern to be in compliance with homicide law and the longstanding norm that doctors should not kill their patients for any reason. As I see it, homicide law and the norms against physician-arranged death is based on an overarching norm that calls for the respect for human life, even in its waning form, because every human life has a fundamental and ineliminable dignity. Hence, I defend the following argument: (1) transplant protocols that would have us secure the donor's death would have us kill someone for their organs; (2) killing someone for their organs disrespects the worth of someone; (3) no act that disrespects the worth of someone is permissible; (4) therefore, protocols that would have us secure the donor's death are impermissible. This deductive approach to the issue indicates my intention to defend a moral absolute: It is wrong for transplant surgeons to kill their donors *always and everywhere* — even with their consent.

I defend this argument in each chapter. I begin with an analysis of our nature and our deaths. I contend that the answer to the question "What are we?" is the answer, "a human organism" and that "death" marks the end of the biological life of a human organism, not a psychological entity distinct from a human organism. I then defend the currently accepted neurological criterion as being sufficient for determining death. Next, I clarify what is meant by "transplant protocol" and "kills" and what it is to kill someone "for their organs." Along the way, I contend for a theory of intention that seeks to balance out our first- and third-personal perspectives with respect to determining what counts as an intentional action.

Moving to the second premise, I argue that the fundamental problem with lethal transplant surgery, to which I assume the donor consents, is that it bestows more worth on the organs than the donor who has them. At stake is the very basis of human equality, which is an ineliminable dignity that each of us has in virtue of having a rational nature. To allow mortal harvesting would be to make our worth contingent upon variable quality of life of judgments that can only be based on properties that come in degrees. Thus, rejecting the ban on killing donors comes at the expense of our egalitarian principles, which require equal treatment insofar as protections from being killed are concerned. In short, the ban on killing is a matter of respect.

I end by explaining why this respect and our egalitarian principles require this treatment, and why it is at least "virtually" absolute if not categorically absolute (the third premise). The fundamental problem with non-absolutist systems of morality is that they only superficially differ from consequentialism, a moral theory most bioethicists are loath to accept. I give some reasons why consequentialism is inadequate, and explore options

for grounding the DDR as a moral absolute. Yet my case does not depend on the falsity of consequentialism, since a rule-consequentialist could hold that the DDR is "virtually" absolute because upholding it produces the best outcomes. I explore some of the reasons why this may be so. In any event, we have good reason to think that protocols that would have us secure the donor's death are impermissible.

Preface

Typically, whenever anything is written about transplant ethics, the stark difference between the number of people in need of healthy organs and the number of people who get them is noted.[1] Then it is inferred from the tragic disparity between the short supply and high demand of healthy organs that there is an urgent imperative to increase their number. Various strategies are then explored to do this. Some say we should allow organs to be bought and sold (Matas 2008). Others who want to stay within the charitable giving model suggest that consent to donate should be presumed unless one has previously "opted out" (Thaler and Sunstein 2009, chap. 11). A more aggressive strategy is just to conscript organs regardless of the wishes of those who are made to supply them (Harris 2002). Still others, who resist changing our donation and consent-giving practices, advocate for revising the definition of death so as to include those who have irreversibly lost consciousness as potential organ sources (Veatch 2010, 322). Those who hesitate to further revise the definition of death reject the rule that vital organs should not be removed from living patients and that "organ donation euthanasia" should be permitted (Miller, Truog, and Brock 2010; Wilkinson and Savulescu 2012). While it is routinely acknowledged that any one of these proposals would require a radical shift in our understanding of transplant ethics, we are left with the impression that almost

[1] At the time of this writing, the Organ Procurement and Transplant Network website of the U.S. Department of Health and Human Services says there is over 120,000 people in need of a life-saving organ; in 2015, there were 15,064 donors who supplied organs for 30, 973 transplants (accessed March, 21, 2016).

anything is better than the status quo. So great is the imperative to maximize the organ supply that no time-honored belief in medical ethics, whether it be concern for bodily integrity, informed consent, economic fairness, the wrongness of killing, or even the nature of life and death, is safe from critical scrutiny. While there is much to be said for and against all of these proposals, it is the revision to the wrongness of killing that concerns me the most: I do not think there is anything wrong with the status quo's prohibition against donors being killed for their organs.

For the last twenty-five years the so-called "dead donor-rule" (or DDR) has been the object of an increasingly intense scrutiny. While the content of the rule is not always precisely understood, the rough version is that retrieving organs for transplant should not come at the expense of the donor's life, and so vital organs like the liver, heart, or lungs should not be extracted unless the donor is dead. A chorus of discontent with the rule has been voiced by a small, but growing group of doctors, lawyers, and philosophers who believe it is permissible for transplant protocols to be the cause of death for donors of vital organs. The reasons for this are many and varied, as we shall see, but all who reject the DDR have in common the concern for harvesting the healthiest organs possible, the reasonable assumption being that living donors at the margins of life are a healthier source of organs than freshly dead ones. My twofold aim is to first *challenge* those who believe that the moment of the donor's death is not morally important in the context of organ donation, and that the donor's death can be licitly secured by transplant surgery protocols, and secondly to *defend* a version of the DDR that specifically forbids killing the donor as a sound moral policy. The reasons for this will unfold, but to prime the pump a bit, I shall begin by illustrating them with a sad but thankfully untrue story.

An infant boy named Joey, who was dying from causes related to birth asphyxia, could not be saved. Hoping to lessen the tragedy of the situation, Joey's grief-stricken parents quickly made provisions for Joey to become an organ donor so that they might spare the life of another little one in need. As it happened, there was such a little one in need named Tommy who was at the same hospital at the same time. The transplant team decided to use a donation-after-circulatory-death protocol to retrieve the tiny heart, which could be promptly transplanted into Tommy the same day (similar to the one of Boucek et al. 2008). Life support was withdrawn from Joey, and fifteen minutes later he flatlined. The doctors waited an additional seventy-five seconds, and then began the delicate surgery to retrieve the heart; they successfully extracted it, and transplanted it into Tommy. The heart was restarted and Tommy made a full recovery and showed signs six months later that he would continue living a healthy life. Joey's parents found solace in their grief that the surgery was a success — their son's short life made a lifesaving difference to another.

Unfortunately, Joey's parents later met a bioethicist who told them that Joey was not dead at the time of transplant. Seeing that he had stunned the parents with this bold assertion, he went on to explain that death is an *irreversible* event, and since Joey's heart was able to be restarted, it was not the case that Joey's circulatory function had irreversibly ceased, and therefore the criterion for cardiac death named in the Uniform Determination of Death Act was not satisfied.[2] Indeed, the heart could not have saved Tommy's life if it could not been restarted. The cause of death, the bioethicist argued,

[2] The Uniform Determination of Death Act states that an individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead.

was not the effects of birth asphyxia; no, death occurred during transplant surgery. Profoundly disturbed by these claims, Joey's parents asked, "You mean we consented to our son being killed on the operating table? We were not informed of that." "Of course not," the bioethicist huffed, "But don't worry, what you did was unquestionably right. What we should really be worried about is this silly rule that says donors should not die as a result of their surgery — that is why you weren't properly informed."

While we might agree that the bioethicist should be more sensitive to the parents and their situation, there are many who agree with his argument. I do not. I intend to defend the claim that the bioethicist is simply *wrong* to think that the cause of Joey's death is morally irrelevant to the act of organ donation, and that he is wrong to blame the DDR for undermining trust in the transplant enterprise. Conversely, Joey's parents are *right* to worry about whether the surgery killed their son, because they rightly recognized the value of his life even in its waning state. They do not suffer from some irrational moral bias that fools them into thinking that his life is sacred, nor are they victims of some conspiratorial legal fiction that makes taboo the killing for organs with patient or proxy consent. Finally, it is right for us to wonder whether Joey's parents were misinformed about the nature of death or what the specific protocol used on their son entailed (or both), and that *those* things, and not the DDR, should be singled out for scrutiny. This is because Joey was a human being, who was lovingly carried by his mother for nine months and would have slept in a room his father helped prepare for him. In their eyes, to use the tired jargon of moral philosophers, Joey was a member of the moral community, and ought to have been treated as such.

But what if Joey's parents didn't value him so much? Suppose they were like the parents in the infamous "Who Should Survive?" movie, who forbid the attending physician to operate on their newborn son (who was diagnosed with Down's syndrome[3]) to correct an intestinal blockage. They *want* Joey to die, and instead of waiting impatiently for him to starve, they consent to the transplant surgery knowing that their troubles will soon be over and that someone else will be benefitted. Is Joey still a member of the moral community and should his life not be taken by the transplant surgeons regardless of what his parents think? I answer in the affirmative to both questions. Joey's parents are *wrong* not to value him, and that killing him for his organs does not respect his worth, and therefore is bad medical practice. But why? Fundamentally, the answer lies in the failure of the parents to acknowledge the innocence and helplessness of Joey as a small dependent human being, who, as such, is inherently valuable. That they are indifferent to their special obligation as parents to care for him also matters, but this is less fundamental; Joey would still be worthy of protection even if his parents were dead. Likewise, good medicine shows a proper respect for the worth of human life when it is sensitive to our dependence and does not seek to take advantage of it as it would if it were to permit killing people like Joey. In short, they would fail to care for him. Joey's worth derives from the kind of beings he is, and is respected when our institutions care for such beings whether they are young, old, or infirm. Even in his injured state, he ought to be treated as an end, not as a means to an end. It is simply a matter of respect, which is both a matter of justice and good medicine.

[3] I am aware of the spelling dispute between "Down" and Down's" and while I generally prefer "Down" I use "Down's" in this dissertation, since those with whom I interact use "Down's" and I prefer a consistent usage that avoids having to write out "[sic]" every time after their spelling.

This leads me to my argument in defense of the DDR, which rests on the premise that someone, even at the margins of life, is valuable to such an extent that they should not be killed for utilitarian purposes. As stated, it goes like this:

1. Transplant protocols that would have us secure the donor's death would have us kill someone for their organs.
2. Killing someone for their organs disrespects the worth of someone.
3. No act that disrespects the worth of someone is permissible.
4. Therefore, protocols that would have us secure the donor's death are impermissible.

As we shall see there are several objections to this argument. Some draw a distinction between biological and mental life such that the loss of mental life is equivalent with the death of the individual, and that the "someone" referenced in premise [1] is entirely lost just if the capacity for consciousness is irreversibly lost making the killing of the donor's biological life a different sort of act with a different sort of consequence. Others might claim that killing must be intended, and that the death of the donor could merely be a foreseen, but unintended side-effect of a protocol that is only aimed at removing vital organs for the sake of aiding the recipient, and therefore does not constitute an act of killing. Against premise [2] one might appeal to a principle of autonomy as expressed through informed consent that allows a donor to authorize the transplant team to intend the donor's death without any loss of respect. Along similar lines, some believe the norms against disrespect can be reduced to norms against harm, and that vital organ donors only need to be "beyond" harm, a point at which allegedly comes before death. Still others think none of this matters and that premise [3] is ambiguous, and that we can satisfy the demands of respect when we give everyone due consideration in a moral calculus that requires us to maximize the good; perhaps under very special circumstances,

one may be killed for the sake of the greater good and that this practice can be codified in public policy. Each of these objections will be taken in their strongest form and (hopefully) answered with the best possible reply.

What follows, then, is a formal defense of each premise of the argument. Chapter One sets the stage of the topic and gives an overview of the DDR, it's history, its correct formulation, and why it is being challenged today. Chapters Two and Three are defenses of the first premise by clarifying the nature of death and what it means to secure someone's death through the use of a transplant protocol. Chapter Four defends premise two and Chapter Five clarifies what is meant by "respect" in premise three. The deductive character of my argument is meant to leave no exceptions to its conclusion. Therefore, I embark on a task of defending a moral absolute, that killing donors for their organs is morally wrong, *always and everywhere*.

While the scope of my project is limited to explaining the wrongness of killing in the context of organ donation, it has implications for other topics such as abortion, embryonic stem cell research, euthanasia, physician assisted suicide, the death penalty, and the use of lethal force by the military and police. These I leave unexplored. The argument I defend here is meant to be as specific as possible for the organ donation context, because I intend to represent a philosophically worked out view in support of traditional medical ethics against surgery-related killing, something that is lacking in the DDR literature. Even as late as 2012, in what is perhaps the most systematic presentation of the argument against the DDR, Franklin Miller and Robert Truog write that they "are not aware of any systematic effort to justify this rule" (Miller and Truog 2012a, 114). There are some good reasons for this. Historically speaking, a traditional medical ethic

informed by the Hippocratic Oath and a religiously grounded sanctity-of-life doctrine deeply shaped the ethics of vital organ transplantation when it first attracted ethical attention some fifty years ago. But its inchoate premises were largely assumed without argument, and the progressive nature of the mostly secular bioethics movement in conjunction with technological advances over the last fifty years have led many to scrutinize and reject the classical foundations of the DDR. Part of my task is to scrutinize the scrutinizers by defending an argument that, in my view, contains premises that are difficult to disagree with unless one is committed to more controversial prior assumptions. It is those assumptions I would like to test; I am confident that the plausibility of those assumptions is not greater than the plausibility of the premises of my argument, which I will labor to develop in due course.

The astute reader will wonder if Christian belief motivates the direction of my argument. I will not deny it. Nor do I feel guilty for doing so, since I do not believe it is possible to be religiously neutral about of the value of life and the wrongness of killing. What intellectual space is there that is both independent of assumptions for and against religion, and sufficient for engaging in sound philosophic reasoning about matters of life and death? Thinking about these topics from behind Rawls' veil of ignorance is the one serious candidate offered in recent times (Rawls 1971), but I believe it fails to provide any firm ground for settling questions concerning the moral status of animals or human beings at the margins of life. Do we know if we will be human or not under the veil? Are we even human at all (perhaps all we are is a conscious brain)? The only way to settle these issues is through philosophic argument from flesh and blood thinkers like ourselves, culturally embedded as we are. Nonetheless, nothing I offer here will be

religiously exclusive, meaning that one cannot rationally assent to my position unless one shares my particular religious beliefs. Rather, I operate under the assumption that an omnipotent and loving God would make us capable of discovering moral truth, and that believers can make their beliefs rationally intelligible to non-believers by integrating religious beliefs, on the one hand, with "secular" considerations, on the other. Since in our stage of world history, more "publically available" reasoning is required to shape our policies, I am happy to engage in this sort of reasoning if only to be more philosophically persuasive. But that is not the only reason. I also see my project as helping to explain why someone of a religious persuasion would hold my position. Appeal to divine commands against killing and assent to doctrines that place an incalculable worth on human life do not go very far in explaining the point of such commands or the properties in virtue of which we have such a worth. Thus, the sort of project I am engaged in assumes that there is a common good for human beings, and that, at least in the context of organ donation, everyone who is interested in safeguarding and improving that common good can speak to one another from whatever point of view they find convincing, whether they be Christians, Jews, Muslims, Hindus, Buddhists, or atheists. Of course, disagreement will persist, perhaps because of ultimate prior commitments. Nevertheless, finding out where those disagreements lie (and do not lie) is still a worthwhile exercise.

What follows, then, is an argument that is perhaps best at home in the Aristotelian tradition, broadly construed. A teleological view of human life and human action is defended in the coming pages. I stop short, however, of assuming a full-blown teleological view of ethics as I retain a concept of "dignity" that may be thought to be Kantian in character. I note the conflict between these two ethical traditions, but am

unable to fully eliminate it. The reason for this is that I am unable to make sense of the phenomenon of *wronging* something and not merely *acting wrongly* towards it, which is why I frame things in terms of respect that must be owed, and not merely in terms of an upright will towards the good. The character of justice seems to me to require a patient- rather than agent-centered ethic that imposes inviolable side-constraints on our pursuit of the good. I make no formal attempt at working out an ethical theory that would be able to do this work, though I see myself following after Alan Donagan and his underappreciated work *The Theory of Morality* (1977).

This project would not have been possible for the unfailing commitment of my wife Rebecca, who for the past eight years has faithfully supported me through two graduate programs in philosophy. It is hard to put into words how grateful I am to her for allowing me to pursue this project. Not everyone has the opportunity to pursue their calling and produce what they might proudly call their life's work. Even if I do not continue on in philosophy or bioethics, I will able to say that I was able to spend a tenth of life (if I am lucky to live to 80) doing what loved to do largely because of her love and her faith in me. I can only hope that I have done her proud.

A large debt of gratitude is owed to my supervisor Christopher Tollefsen who carefully read over several drafts of this dissertation and made countless comments, clarifications, and criticisms that made the argument much stronger than it otherwise would have been. His guidance and support are especially noteworthy in his patience with my mistakes and his welcoming of disagreement with his some of views. I especially thank him for recommending me to study with him and his colleagues at

Princeton University in seminars on medical ethics, public affairs, and Thomistic studies, which greatly helped me work out my views.

I must also thank my committee members Jennifer Frey, George Khushf, and Jeff Bishop for their help in this project. I particularly thank Jennifer for hiring me as her research assistant for her Virtue, Happiness, and the Meaning of Life project in which I was able to not only learn a great deal from her, but also her colleagues in formulating a theory of action and assessing the merits of consequentialism. I especially thank George for leading the (now defunct) bioethics reading group in my first years of graduate school, which helped further my interest in brain death and organ donation ethics; he has had no small impact on the content of my views, especially with regard to brain death and its place in our public policy. Lastly, I thank Jeff for agreeing to be an Outside Reader on my committee despite his busy schedule and his own supervising duties at St. Louis University. The challenging feedback I received from him helped improve my historical understanding of an area that should receive more attention from medical ethicists. Indeed, the support I've received from these four could not have been better.

Table of Contents

Chapter 1: How (not) to think of the 'dead-donor' rule

Abstract: Although much has been written on the dead-donor rule (DDR) in the last twenty-five years, scant attention has been paid to how it should be formulated, what its rationale is, and why it was accepted. The DDR can be formulated either in terms of a Don't Kill rule or a Death Requirement, the former being historically rooted in absolutist ethics, while the latter in a prudential policy aimed at securing trust in the transplant enterprise. I contend that the moral core of the rule is the Don't Kill rule, not the Death Requirement. This, I show, is how the DDR was understood by the transplanters of the 1960s, who sought to conform their practices with ethics, unlike today's critics of the DDR who "rethink" our ethics in a question-begging fashion so as to accommodate our practices. A better discussion of the ethics of killing is need to move the debate forward.

Dr. Giertz spoke of taking organs from a dying person. I would like to make it clear that, in my opinion, there has never been and there will never will be any question of taking organs from a dying person who has "no reasonable chance of getting better or resuming consciousness".

— G.P.J. Alexandre[4]

1.0 Introduction

In the past twenty-five years, much work has been published on the so-called "dead-donor" rule (DDR) and the alleged problems it poses for organ transplantation. Most of this literature is critical of the rule and calls for its abandonment, yet the rule's exact formulation is not always clear and the reasons for abandoning it are not always sound. Indeed, as I shall argue in the first section, there are two distinct ways of

[4] Quoted in (Wolstenholme and O'Connor 1966, 154)

formulating the rule, each of which lend themselves to distinct ways of justifying them. On the one hand, the DDR is interpreted as a requirement that the donor be dead before surgery begins, a rule that appears to form a prudential policy essential for securing the trust of potential donors in the transplant enterprise. On the other hand, it is interpreted as a norm against intentionally killing the innocent via transplant surgery, a norm that is historically rooted in the absolutist ethical systems of Kantian deontology, natural law theory, and religious ideas embedded in Judaism and Christianity — not in principles of utility.[5] Hence, it is insufficient to argue from the premise that the DDR has negative effects on donor trust (assuming this is the case) to the conclusion that it should be rejected (e.g. Chaten 2014), since the validity of the norm against killing individuals for their organs need not depend on whether the killing produces good consequences. As a deontological constraint, the DDR forbids lethal transplant surgery as a type of action — and this, as I shall defend in the second section, is the moral core of the DDR. While the theoretical limits of this constraint are hotly debated today, it was originally received as an absolute ban on lethal surgery. As will be shown in the third section, the early transplanters of the 1950s and 60s had good reasons for understanding the rule this way, and they labored to make their practices conform with the law and long-standing ethical principles concerning the ethics of killing. Today, however, we see something of a reversal of this pattern of thought; critics are eager to "rethink" the ethics of killing and laws against homicide so as to permit lethal practices they assume to be acceptable. In the

[5] Lest there be any confusion, the kind of "absolutism" I have in mind is the kind Anscombe described when she spoke of there being "certain things forbidden whatever *consequences* threaten" and "simply in virtue of their description as such-and-such identifiable kinds of action…" (Anscombe 1958b, 10 emphasis original).

fourth section, I take issue with this assumption because the question is begged against the traditional reasons that the DDR was adopted for in the first place. Since our medical practices should conform with sound ethical principles no matter how much we may desire for them to be acceptable, I end by calling for the continuation of a more thorough and consistent discussion of the reasons why we should reject the norm against killing the innocent in general and why it should be permissible for doctors to kill for organs in particular. While this may be well-worn territory, it is "the only game in town" for moving the debate forward. Let us now examine this case in greater detail.

1.1 What does the rule prohibit?

Careful thinking about the DDR requires a clear formulation of its content. Surprisingly, this step is often glossed over. A sample of the literature reveals two different ways in the DDR is formulated, one of which I will call the "Death Requirement" and the other I call the "Don't Kill" rule.

Table 1.1 Two ways to formulate the DDR

Death Requirement	**Don't Kill**
1. "It is thought permissible to retrieve vital organs only from dead patients." (Miller and Truog 2008, 38). 2. "A patient should be dead before vital organs were [are] removed" (Fost 2004, 249). 3. "The donor must be dead before vital organs are procured" (Bernat 2008, 670). 4. "Multiple vital organs should only be taken from dead patients" (Coons and Levin 2011, 236).	1. "It is immoral to kill patients by taking their organs" (Koppelman 2003, 1). 2. The DDR "requires that donors not be killed in order to obtain their organs." (Robertson 1999, 6). 3. "Individuals must not be killed by organ retrieval" (Rodríguez-Arias, Smith, and Lazar 2011, 36). 4. "The DDR states that organ donation must not kill the donor; thus, the donor must first be declared dead" (Bernat 2013, 1289).

As stated, the Don't Kill rule is less demanding than the Death Requirement because it permits vital organ procurement in cases where surgery is causally unrelated to death, where the Death Requirement does not. While commonsense suggests that removing a vital organ like the heart would cause the death of the donor, this is not necessarily the case in practice. Astonishingly, the heart can be removed without killing the donor in what is called a "domino donation." In this protocol, a donor with a healthy heart, but diseased lungs, can donate her heart to someone else, and receive a healthy heart and lungs *en bloc* from a dead donor (Robert Sade, October 26, 2015, e-mail message to author). To be sure, those who deploy the Death Requirement in their writings would probably deem this practice as acceptable, and admit that the Death Requirement, as stated, is imprecise.[6] Critics of the rule have a point, then, when they say that the ethically relevant question is not "When is the donor dead?" but rather "When is it permissible to remove vital organs from the donor?" (Fost 2004, 251). However, death is still an important part of answering this question if the donor's death is not to be intended (Fost 1999).

The Don't Kill rule, by contrast, says that it is impermissible to remove vital organs from the donor if the donor would be killed by their removal, since the donor's death should not be intended for the sake of retrieving organs.[7] Some critics and

[6] Or, as an anonymous reviewer suggests, they might even consider the particular organs harvested in this specialized context as technically "non-vital."

[7] One should not interpret the DDR so narrowly as to think that it only forbids killing *by* removing one's, but not killing *for* obtaining organs (*pace* Coons and Levin 2011). The fact that one could consent to be killed by the surgical removal of organs, but not for the sake of their removal is simply irrelevant in the context of organ donation, the context to which the DDR applies (such a person isn't a "donor" at all). In that context, no donor is indifferent to the good of having one's organs harvested for the sake of helping others, and no transplant team is indifferent to the good of harvesting healthy organs for transplant.

defenders of the rule agree that this is its morally relevant formulation, being a species of the more general norm against harming patients.[8] Critics of the rule, like Franklin Miller and Robert Truog, recognize that it "is based on the seemingly unassailable principle that it is wrong to kill (or cause the death) of an innocent person to save the life of another" (Miller and Truog 2008, 38). Moreover, as George Khushf, a defender of the rule, explains, the rule "excludes organ-harvesting practices that bring about mortality" (2010, 356n1), or put another way, "no person can be killed in order to harvest organs" (Ibid, 331). Therefore, the ill-named 'dead-donor rule' should be interpreted primarily as a reference to the norm against killing donors for their organs, and not primarily as a proscription against the removal of vital organs from living patients, as commonsensical as that might be.[9]

What, then, explains the prominence of the Death Requirement? Although the Don't Kill rule is the essential moral core of the DDR, one might think that the Death Requirement is the best policy to adopt to avoid risking abuse and to secure donor trust. Obviously, transplant surgery is less controversial when the donor is dead. Technically, however, the Don't Kill rule allows vital organs to be procured so long as the donor is not killed by the procedure, and these surgeries are much more controversial. For example, under Paul Morrissey's proposal, a surgeon may remove *both* kidneys from someone who is irreversibly brain-damaged but does not satisfy neurological criteria for death

[8] This would also rule out procurement procedures that would leave individuals in a diminished state even if they were not killed.

[9] Levin is one of the few writers on this topic who notes the difference between the Death Requirement and the Don't Kill rule, but he thinks that the Death Requirement is the "historically accurate" formulation despite conceding that "the origins of the DDR are unclear" (Levin 2013, 2–3). Both of these claims I shall contest below.

(Morrissey 2012). Under this protocol, a designated proxy authorizes the removal of the kidneys before life-support is removed; once the kidneys are retrieved, life-support is withdrawn and the donor dies of respiratory complications. Assuming the cause of death is related to the fatal brain trauma and not to the absence of kidney-functioning, the Don't Kill rule is not violated.[10] Crucial to this proposal are the certainty of the diagnosis of imminent death and the substantial cause of death.[11] This is a demanding standard, and any errors in diagnoses would be catastrophic for the patient, while implicating the surgeon in the donor's death. Even if the diagnosis is correct, doctors must still consider the risk of the surgery's being the proximate cause of death.[12] To avoid any risk of violating the Don't Kill rule, then, the best policy is to satisfy the Death Requirement, a standard Morrissey's proposal does not meet. Thus, a precautionary approach that avoids contravening the Don't Kill rule gives the Death Requirement its normativity. The normativity of the Death Requirement may also be reinforced with the belief that it best

[10] Some contend that the Don't Kill rule is violated because withdrawing life-support is what "causes death" not the underlying pathology (Miller and Truog 2012a, chap. 1). While this requires fuller treatment, my quick reply is that framing human action in terms of its causal activity or inactivity is a poor way to understand human action. Does a boy scout "cause the death" of his breathless and unconscious scout master (imagine some accident out on the trail) when he ceases to perform mouth-to-mouth resuscitation after an hour? The fact that the scout master could have lived longer had the scout not given up is not sufficient for helping us understand what the scout *does* — certainly he does not kill him. It seems that there is at least a morally relevant distinction between being *a* cause of death (which may affect the timing of it) and being *the* cause of death (which is the source of the fatal sequence) (Birch 2013). This is not to say that someone's death cannot be intended by withdrawing life-support, but doing so does not require such an intention. For further treatment on this topic see Jensen (2011).

[11] This is also the source of the controversy over so-called "donation-after-circulatory-death" protocols.

[12] According to critics of Paul Morrisey's proposal:

> Midline laparotomy and bilateral nephrectomy [the procedures that remove both kidneys] after the original brain injury is an additional iatrogenic (penetrating and blunt) trauma resulting in extracranial tissue injuries and potentially hastening or causing death. Surgery can induce post-operative cardiovascular instability secondary to blood loss, intraoperative fluid shifts, and intravascular hypovolemia. In the absence of optimal perioperative resuscitation, the final common pathway is an early onset of hypotension and cardiovascular collapse. The latter becomes the lethal pathophysiology and proximate cause of death upon WLS [withdrawing life-support] (Wertin, Rady, and Verheijde 2012, 18).

protects the patient's end-of-life care from being compromised and, therefore, better secures donor trust in the transplant system. For these reasons, then, the stronger Death Requirement might be preferable to the weaker Don't Kill rule, which would help explain its prominence.[13] Yet if the risk of violating the Don't Kill rule were shown to be tolerable, and the patient's end-of-life care were able to be safeguarded, Morrissey's proposal would be permissible insofar as the Don't Kill rule is concerned. What is at stake, then, is the suitability of certain protocols that do not meet the more risk-averse Death Requirement: are they safe enough to practice or would we risk killing the donor? How Morrissey's proposal is adjudicated will depend not only on the answer to this question, but also on the interpretation of the rule favored as a matter of policy. What is important to understand for our purposes is that the moral core of the DDR is the Don't Kill rule, and the Death Requirement is the operational result of a precautionary approach to complying with it. This framework has important implications for understanding its purpose.

1.2 What is the rule's purpose?

The DDR is commonly recognized to be a deontological constraint on our efforts to maximize the number of transplantable organs, but the meaning of this notion is unclear. In a broad sense, it means that, regardless of the consequences, we must not instrumentalize donors to such an extent that they can be killed for their organs. Yet the

[13] This sort of thinking is captured well in DeVita and Snyder's description of four cases in which donation-after-circulatory-death protocols were used (1993). They report that, in the effort to standardize these protocols, some transplant teams and procurement officials were concerned "that an overly liberal policy might result in a public outcry that would jeopardize the future of organ donation" (Ibid., 135) I take what they mean by an "overly liberal policy" to include removing vital organs from donors who have satisfied neither neurological, nor circulatory criteria.

limits of this constraint are up for debate. Can donors be killed for their organs if they give valid consent? Or would such cases be ruled out because they involve killing the innocent?[14] The answer depends on which form of deontology is at work. If it is the variety one finds in Tom Beauchamp and James Childress' widely-read *Principles of Biomedical Ethics* (2013), then exceptions to the Don't Kill rule can be plausibly formulated through the mechanism of voluntary informed consent. But if it is the absolutist variety that derives from Kant's ethical system, natural law theory, or Judeo-Christian morality, then no exceptions can be made — the Don't Kill rule is simply meant to forbid this type of action. Rather than address this philosophical debate here (see Chapter 5), I will just say that the historical understanding of the DDR in the 1960s favored the absolutist sort (see below for details). The particular reasons for why this understanding was favored depend on the tradition assumed, but a respect for the inviolateness of innocent human life is the underlying concern. Interestingly, some critics of the ban recognize that its character signifies society's respect for human life (Cochrane 2011, 136), while some of its defenders pass over this entirely and emphasize its utility, claiming that compliance with it is essential for securing the trust of those who might be willing to donate (Chen and Ko 2011). Donor trust, it is thought, would be curtailed if the rule were routinely violated (Bernat 2013, 1290). These two streams of thought are often blended together in ways that make the purposes of the rule reducible to respecting persons and avoiding harm (e.g. Collins 2010, 164). As today's bioethicists tend to work out their policies in terms of a quasi-rule-utilitarianism where principles of respect are

[14] There is a question about the "non-innocent"—people on death row—which I leave aside, since such a practice depends on the validity of the death penalty, an issue that needs to be resolved before any "death-by-transplant-surgery" proposal can be evaluated.

"balanced" against principles of beneficence (e.g. Jonsen 2001, 44),[15] the purpose of the rule is thought to be twofold: (1) to protect the interests of the donor, and (2) to secure the goods necessary to further the goals of transplantation. This more pragmatic interpretation of the rule explains why some think the DDR "never really has been a rule, but rather a guideline" (Fost 2004, 252). This, however, is an impoverished view of the rule's purpose. To see why, I shall examine two flawed criticisms of the rule that depend on these assumptions.

1.2.1 Not about successful mediation

Critics of the DDR typically contend that the rule should be rejected if it is at odds with respect for persons or if it fails to secure the trust it promises (Koppelman 2003; Miller, Truog, and Brock 2010; Rodríguez-Arias, Smith, and Lazar 2011, 36; Sade 2011; Chaten 2014). This contention is an instance of a more general strategy, which argues against the rationality of accepting an absolute prohibition from the premise that perfect compliance with it frustrates the purposes of the prohibition (Shafer-Landau 2015, 230). Perhaps the best example of this critical framework comes from Elysa Koppelman, who thinks the DDR ought to be discarded because it can no longer "successfully mediate" the utilitarian goal of maximizing the organ supply with the deontological value of respecting the wishes of donors who are irreversibly unconscious (2003, 2). Successful mediation of these goals is what she believes characterizes the concerns of the transplant community. While she formulates the DDR in terms of the Don't Kill rule, she believes that compliance with it requires a precise definition of death if the surgery needed for

[15] Albert Jonsen is worth quoting: "To be more precise […], the 'rule utilitarianism' that combines respect for rule and principle with the goals of human and social thriving is the dominant ethos of bioethics at the level of public policy" (Ibid.).

successful transplant would otherwise kill the donor. Since there is a lack of consensus on the definition of death, she concludes that the DDR "cannot mediate the concerns of the organ transplant community," and if we assume that respecting persons and killing them are incompatible, "we risk compromising the utilitarian goal." To achieve a more optimal balance between the utility of maximizing the organ supply and the deontological value of respecting those who supply them, we ought to permit donors to negotiate their deaths with their transplant surgeons.

There are two problems with this argument. First, it is doubtful that the purpose of the DDR is to "successfully mediate" the delicate balance between the good of maximizing the organ supply and the good of respecting those who supply them. Instead, the DDR is meant to *conflict* with the utilitarian goal — it is not meant to identify a neutral space of moral ground where the principles of beneficence and respect for persons can meet.[16] The rule just is meant to forbid a certain kind of action from being performed on the donor's body.

Second, there is no good reason why a lack of consensus on a topic is sufficient to reject rules that involve the topic. Koppelman's argument seems to be this:

1. The DDR requires a precise definition of death.
2. There is no consensus on the definition of death.
3. Therefore, the DDR ought to be rejected.

I shall call this the No Consensus argument. Its general form goes like this:

1. Rule R concerning Q requires that there be a precise definition of Q.
2. There is no consensus concerning the precise definition of Q.
3. Therefore, R should be rejected.

[16] I take her language about "utilitarian" and "deontological" values to be indicative of a conflict between the standard bioethical principles of beneficence and respect for persons, not utilitarian or deontological ethics in a theoretical sense.

Is her application of this argument sound? I think not. Consider this argument:

1. Rules that protect the free exercise of religion require a precise definition of "religion."
2. There is no consensus on the definition of "religion."
3. Therefore, rules that protect the free exercise of religion ought to be rejected.

Yet we have good reason to accept rules that protect the freedom of religion despite the fact that there is no consensus on the definition of religion (Choper 1982).[17] Some of those reasons involve the principles of beneficence and respect for persons, or other principles upon which any just society is based (Nussbaum 2012). The same is true of rules protecting ideals like free speech or the freedom to marry, or rules that make use of disputed concepts like race or gender. Yet the No Consensus argument would have us believe that any term lacking a consensus definition is grounds for rejecting rules that make use of them. There is simply no reason to believe this. One might reasonably conclude the rules are problematic or in need of refinement, but the implication that they should be rejected does not follow.

I will grant that perhaps I am missing something important about when and why a rule's terms need to be clearly defined. Nonetheless, it is not obvious that the DDR requires a precise definition of death. Under the Don't Kill formulation, at least, one is in need of a good understanding of *life*, and the knowledge of how not to take it — not a precise definition of death. But what about the Death Requirement? Is it not the case that a

[17] I should acknowledge that "religion" is not adequately analogous to "death" because there is a good reason to leave "religion" vague: there are multiple forms religion can take that are widely different from one another. Not so with death, which formally is just the cessation of life, and when that occurs is something we should get right. To offer a better analogy I will replace the argument with one concerning "disease": (1) Rules that govern the control of disease require a precise definition of "disease"; (2) There is no consensus on the definition of "disease"; Therefore, (3) rules that that govern the control of disease ought to be rejected.

precise definition of death is necessary to determine when we can safely remove vital organs? Surprisingly, the answer is no; a *precise* definition of death is *not* needed when people donate their brain to science. No one worries about satisfying rigid death criteria when the brains of former football players are removed upon autopsy so that they can be studied for the purposes of diagnosing chronic traumatic encephalopathy (popularly known as CTE). Rather, the requirement is generated by procedures that intend to retrieve the healthiest organs possible for transplant and that accept the DDR as a constraint. Thus, it is the medical goals of organ transplantation in conjunction with the constraint of the Don't Kill rule that require a precise definition of death. Yet many critics of the rule believe that either version of the DDR alone imposes this requirement. This is an instance of a broader trend in the DDR literature, which I call "slanting" (for lack of a better term): attributing things we do not like to a single factor, while ignoring the relevance of other factors.

1.2.2 Not about creating virtuous activity or good consequences

A notable example of slanting comes from Frank C. Chaten (2014), who asserts that the DDR has failed to perform its intended function, that is, to safeguard patient trust in the transplant enterprise. According to Chaten, compliance with the DDR "leads physicians to compromise many virtues essential to the excellent practice of medicine" (Ibid., 496) Abolishing the rule will remedy this situation, says Chaten, because it "will strengthen the doctor-patient relationship and foster trustworthiness in organ procurement" (Ibid.). Chaten's critique is interesting in that it is not merely consequentialist; rather, he assumes the virtue ethics tradition as it is situated in medicine by Edmund Pellegrino (2002). The virtues at stake include: (a) fidelity to the patient's

best interests with respect to the desire to donate; (b) intellectual honesty with respect to the nature of death; (c) suppression of self-interest and the courage to support the good with respect to the difficulty of diagnosing death while simultaneously promoting the urgency of altruistic gifting; and lastly (d) compassionate care for the donor with respect to failure to administer general anesthesia to newly declared dead donors for precautionary reasons. Chaten's consequentialist concern is that the application of the DDR at the bedside fails to bring about desirable states of affairs, that is, ones in which physicians accord with virtuous activity. Since transplant surgeons do not accord with these virtues, says Chaten, their activity undermines trust in the transplant system. To safeguard trust, then, we ought to reject the DDR.

Supposing for a moment that the primary purpose of the DDR is to safeguard trust (which it is not), Chaten's argument fails to isolate the DDR from other relevant factors in cases where the rule is applied so that the DDR can be properly blamed for undermining trust. For example, he believes the DDR disrespects donors by limiting their ability to donate healthy organs in cases where the donor does not die quickly enough. However this problem only arises in donation-after-circulatory-death (DCD) cases, not in brain death cases where the donor's body is artificially ventilated. As for brain death cases, Chaten believes that the DDR sometimes forces physicians to impose brain death on donors and their families who for religious reasons do not agree that brain death is death. He cites an example in which he cared for a Muslim child whose parents rejected brain death, believing that death occurs when respiration expires. What goes unmentioned, however, is that these same parents would probably not allow their child to be killed on the operating table either. Hence, it is the medical and legal establishment's

commitment to brain death that creates a burden for cultural and religious values, not the DDR. As unfortunate as it may be when DCD donors fail to die quickly enough to donate healthy organs, it does not follow that the donor's autonomy is disrespected if the acting transplant surgeon refuses to perform lethal surgery. Doctors are autonomous agents too, and by virtue of the respect they are due, they reserve the right to not intend the death of their patients — even in a world without the DDR. Perhaps then we should examine whether our protocols fail to exemplify virtuous activity; maybe they, and not the DDR, are to blame for undermining trust in the transplant system.

Chaten might reply that protocols like those currently used for DCD are the "offspring" of the DDR (2014, 497). If by this is he means that such protocols are the product of a marriage between transplant medicine and the DDR, then so be it — this position is compatible with my claim that the DCD protocols in question may or may not be consistent with virtuous activity. In fact, there is some evidence to suggest that the transplant surgeons of the early 1960s were uncomfortable with harvesting organs after circulatory death. Thomas Starzl remarked that the complicated maneuvering required to procure a healthy kidney after circulatory death led him and his colleagues to fear that they were violating the "spirit" of the "law" — that is, the law against homicide — even if they were following the "letter" of it (1992, 149). Should this discomfort not count as evidence that the DDR had a virtuous effect on early transplanters? After all, the rule's spirit, if not its letter, revealed something important about the character of their actions, which led them to rethink their practices in order that they be able to treat the donor with greater respect. Chaten probably would not agree, however, because he sees the commitment of the early transplant teams to the DDR as an "unexamined choice, not

conceived by thoughtful analysis of alternatives or the result of wisdom obtained from the bedside" (2014, 498). As such, he claims that the rule was put forward merely as a pragmatic solution to the problems facing transplant surgery in the 1960s, and that the pioneers of the discipline did not understand that they were creating the conditions for an imprudent medical practice. Is this true? I think not, and, as I shall argue in the next section, the acceptance of the DDR was the result of complying not only with the law against homicide but also traditional norm against killing patients for any reason, a norm that was stringently re-applied after World War II. This explains, in part, why Starzl and his colleagues thought they were not complying with the "spirit" of the law in the days before the legal recognition of brain death as death.

1.3 Why did the early transplanters accept the DDR?

Since the goal of organ transplantation is to replace an unhealthy organ with a healthy one, the body from which the healthy organ is taken must be in good enough shape to supply one. Assuming vital organ removal would bring about mortality, a dilemma emerges. Either we identify some condition of the donor, which is compatible with the donor being dead and allows for the relevant organs to be healthy enough for transplant, and we remove them only when that condition is reached, or we identify a level of health remaining in the donor at which point lethal surgery is judged permissible and we remove organs only when that level is reached. The dilemma pressures us to either define death precisely and determine reliably when it occurs, or to revise our ethics of killing and precisely define the conditions under which a patient can be killed. In any case, something must be precisely defined if transplantation is to occur.

When confronted with this dilemma in the 1960s, law and medicine opted to "update" the definition of death to include neurological criteria alongside traditional cardiopulmonary criteria (Ramsey 1970, chap. 2).[18] This move is explained in part by the cultural upheavals of the time, which led some to advocate for the legalization of abortion and euthanasia (Fletcher 1954; Williams 1957). What kept the broader transplant community from becoming swept up into a more expansive view of physician-permitted killing? At least some were open to it. Belding H. Scribner, a key innovator in dialysis treatment, said in his presidential address to the American Society of Artificial Internal Organs:

> As far as death is concerned, I would like to be able to put into my will a paragraph urging that when my physician felt that the end was near, I be put to sleep and any useful organs taken prior to death. I wonder how many people feel as I do? I think that ethical and legal guidelines should be devised to permit me and others to volunteer in these ways (Scribner 1964, 211).

I too wonder how many felt the same way as Scribner. As far as I know, the attitudes of early transplanters towards this question have not been empirically studied. Still, we should ask: why did the transplant community lobby for a change in the definition of death rather than in homicide law? This question has three answers, each of which is explored in the next three sub-sections, respectively.

1.3.1 The concern over human experimentation

The first answer is found in the experimental nature of organ transplantation at the time. The startling long-term success of Joseph Murray and others in kidney transplantation highlighted the newfound awkward relationship between such practices

[18] Paul Ramsey's survey of how this "updating" process went about presents the best summary of the relevant issues and events under consideration at the time.

with existing medical, legal, and theological norms (Murray, Harrison, and Merrill 1955; Barry and Murray 2006). It was not clear to anyone at the time how the risks involved for both the donor and the recipient could be justified. Hence, the topic of human experimentation was front and center at the first symposium on transplant ethics held in London at the Ciba Foundation house (March 8-11, 1966). Starzl, who was invited to participate, reported that:

> The appropriate conditions for human experimentation was the foremost concern because the medical atrocities of World War II were still fresh in the collective mind. Three of the European participants (David Daube, Regius Professor of Law, Oxford; Hugh Edward de Wardener, nephrologist at Charing Cross Hospital; and Michael Woodruff, professor of surgery, Edinburgh) had experienced violations of their own human rights almost beyond description during years spent in concentration or prisoner-of-war camps (Starzl 1992, 146).[19]

The Nuremburg Code (1947) and the Helsinki Declaration (1964), both of which were index documents for the symposium, call for the uncompromised protection of the life and the health of the research subject. Experiments involving a high risk of death or disabling injury to the subject are unacceptable according to these documents even if the subject gives voluntary informed consent. This protection applied as much to the recipients as to the donors in the early days of transplantation. Murray, who performed the first successful kidney transplant between identical twins in 1954, saw with clarity that the practice of live kidney donation involved risking the health of a well person so that a sick person might be made well again (Murray et al. 1964, 550). Poor outcomes for the first few liver recipients in 1963 led Starzl and his team to impose a moratorium on the practice for more than three years (Starzl 1992, 105).

[19] In fact, Daube, who fled Germany in 1933, did not spend time in a camp, though his father did (Daube 2008, 9). Woodruff and de Wardener spent time in the notorious Changi camp in Singapore.

Starzl's ethical sensitivity is worth examining in detail. In a 1967 article, he claimed that the dominant tradition of medical ethics required physicians to provide the best care possible to their patients no matter what the circumstances. As he saw it, this viewpoint "placed the concept of the sanctity of human life on a practical foundation," and it should not be abandoned "in the face of advancing technocracy" (Starzl 1967, 33). At the Ciba symposium, he even questioned the practice of removing organs before the cessation of circulation on the basis of neurological criteria and contended that the surgeon and attending physician equally shared the responsibility to protect the lives of potential donors in hopelessly terminal states (Wolstenholme and O'Connor 1966, 70).[20] At the time, he felt that the act of removing a kidney from the body of someone declared dead by neurological criteria constituted "an erosion of the historical medical creed of responsibility to the patient" (Starzl 1967, 36). He even became uncomfortable with live-donation as reports came in about donor manipulation and coercion, and in one case, a donor's death (Starzl 1992).[21] Although his views would change over time to accommodate what is now commonly practiced in transplantation, this transition was not without careful ethical reflection on whether or not longstanding principles of medical ethics were being honored.

[20] Alexandre's neurological criteria for death, which he used in nine separate occasions, included "(1) complete bilateral mydriasis; (2) complete absence of reflexes, both nature and in response to profound pain; (3) complete absence of spontaneous respiration, five minutes after mechanical respiration has been stopped; (4) falling blood pressure necessitating increasing amounts of vasopressive drugs [...]; (5) a flat EEG" (Wolstenholme and O'Connor 1966, 69)

[21] It is worth mentioning that Starzl risked the well-being of prisoners in his initial experiments with live-kidney transplants who were asked to donate a kidney in exchange for nothing. While it seems that his consent practice was fair, he became concerned over the potential for abuse if the practice of procuring organs from inmates spread to other prisons. In an addendum to the meeting's minutes, Starzl noted that he became convinced of this after privately conversing with David Daube about the matter, and the committee agreed that the practice should be discontinued (Wolstenholme and O'Connor 1966, 75–77).

Beyond Starzl, participants at the Ciba symposium took the deontic constraints on lethal medical experimentation as given. When Michael Woodruff claimed that there were "obvious limitations" on living donors as organ suppliers, the reason he gave was this: "no one can donate his heart or liver and remain alive, and the same is true of a person who wants to donate a kidney if he happens to have only one which is functioning" (Woodruff 1966, 10). Looking ahead to heart transplants, G.E. Schreiner curiously said,

> I personally would find considerable ethical objections to transplanting a heart, because no matter how certain the doctor is that he has to remove the recipient's heart, he has in effect to kill the patient in order to do the experiment, whereas if he puts the heart in as an accessory organ at least he avoids this problem (Schreiner 1966, 132).[22]

Even the Parisian physician Jean Hamburger, who thought medical practice should be given wide latitude in shaping ethical norms, was committed to a Kantian framework in which "an awareness of the value of human life" was essential to the training of virtuous doctors (both quotes from Hamburger 1966, 135). Echoing this sentiment, the Italian surgeon R. Cortesini claimed unequivocally that, "The right to life of every individual must be respected up to the moment of death" when laying out his ideas for proposed legislation in Italy regarding organ donation (Cortesini 1966, 174). On the matter of refusing to use children in transplant experiments, David Daube was insistent: if by doing so, medical progress would be hampered, then "it is regrettable, but medical progress must then be hampered" (Daube 1966, 199).

[22] It seems that Schreiner was committed to the odd view that life was essentially bound up with the presence of a beating heart rather than the presence of adequate circulation.

The early transplant community accepted the norm against risky experimental surgery, and its members were anxious to make their newly devised protocols as safe as possible both for the donor and the recipient. The American Medical Association echoed this concern in its ethical guidelines for organ transplantation by including a clause calling for equal protection of both donor and the recipient; in the Judicial Council's view, no less than the "respect for the dignity of man" was at stake ("Ethical Guidelines for Organ Transplantation" 1968, 341–42). While the success of these efforts can be debated, the guidelines do offer an answer as to why transplanters did not advocate for a change in homicide law: effectively killing donors for their organs involved lethal, and therefore forbidden, experimental surgery.

1.3.2 The concern over homicide

The second reason the transplant community advocated for a change in the definition of death rather than homicide law is that doctors did not see themselves as responsible for the deaths of the brain-damaged patients they disconnected from life-support. The diagnosis of death became especially pertinent in circumstances involving homicide. The case of David Potter illustrates the problem well. In 1963, Potter suffered extensive brain trauma from a brawl and stopped breathing fourteen hours after being admitted to the hospital. He was subsequently connected to a ventilator so that one of his kidneys could be harvested for transplant. Twenty-four hours later, the kidney was removed and he was taken off life-support; no spontaneous breathing resumed. The assailant who injured Potter was arrested and convicted of manslaughter by a jury, but his charges were reduced to common assault, effectively absolving him of responsibility for Potter's death (Ramsey 1970, 71). The problem was that no one could agree on the

moment when Potter died. The coroner thought that he was alive when the kidney was removed, the evidence being his spontaneous heartbeat. The physicians argued that the patient was "virtually dead" when he stopped breathing but "legally dead" when his heart stopped. A neurologist contended that Potter was dead before the kidney was removed due to the brain injury; a pathologist concurred and claimed that the removal of the kidney played no causal role in the patient's death (Halley and Harvey 1968). As a result, it was not clear who was responsible for Potter's death. Was it the assailant or the physicians? While it may seem obvious to us today that responsibility lies with the assailant, the law of the day identified the presence of life with a beating heart. Under this view, it is less obvious that Potter's death was caused by the actions of the assailant than by the actions of the doctors. Indeed, a legal commenter at the time suggested that the termination of life-support was the "immediate cause" of death, going on to generalize that "if S causes P's death, a strong argument can be put up for saying that D, the original imposer of the wound, did not and is not guilty of homicide" (Elliot 1964, 78).[23] How this argument is supposed to go is not clear, but the point is that members of the medical profession — people who were trying to save Potter's life — became implicated in his death in ways that made little legal sense.[24]

[23] Miller and Truog, who ardently believe physicians cause the death of their patients when they remove life-support from them (Miller and Truog 2012a, chap. 1), are, in a sense, modern-day witnesses for the defense in the trial of Potter's assailant.

[24] Potter's case was not unique. In May of 1968, Denton Cooley came under scrutiny after procuring a heart from a donor who also suffered severe brain trauma from a brawl. The Harris County medical examiner worried that his autopsy investigation would be compromised if he were tasked with determining the cause of death in someone who no longer had a heart. While he eventually ruled that the cause of death was a result of the massive brain injury, the legal definition of death was thought to be in conflict with the changing medical definition, and it provided the legal space for the defense to assert that it was Cooley, and not the brawlers who were responsible for the donor's death (J. C. Baker 1968, 88; *Newsweek* 1968, 68). While he eventually ruled that the cause of the patient's death was the massive brain injury, the legal definition of death was thought to be in conflict with the changing medical definition, providing the legal

The Don't Kill version of the DDR, then, was put in place because homicide law made physicians liable for the deaths of patients still alive at the time of transplant (Baker 1968, 98; Berman 1968, 751; Kutner 1969, 787; Woodside 1970, 96). Recognizing this, a legal scholar at the Ciba symposium counseled the following:

> In the present state of the law perhaps the only thing that one can be dogmatic about is that if life still continues in the conventional sense — e.g. if there is still a heart beat — then certainly any authorization [for transplant] from relatives is meaningless. The living person, however unconscious and unable to express his own opinions, has to be treated as a living person, and any authority from a relative would be meaningless. The problem therefore becomes one of defining the time of death for purposes of these removals. In the present state of the law I could only advise a client that he would incur the danger of a possible charge of homicide if by removal of an organ he causes death, if life still continues in the conventional sense (Discussant David Louisell Wolstenholme and O'Connor 1966, 98).

Over time, the legal community came to accept brain death as death. It may very well be that defining death in terms of neurological criteria was merely a pragmatic solution to the legal problems faced by the transplant community. Enthusiasm for this solution was evident at both the Ciba meeting, and the Cape Town Symposium (July 13-16, 1968) where protocols for heart transplants were discussed. Yet it is implausible that the DDR

---

space for the defense to assert that it was Cooley, and not the brawlers, who were responsible for the patient's death. The conflict between medical examiners and transplanters came to a fever pitch when Stanford University's Norman Shumway retrieved a heart from the body of a homicide victim without the examiner's authorization. In this case, the defense attorneys *succeeded* in arguing that it was Shumway who killed the victim, rather than the victim's assailant (Jentzen 2009, 121). Similarly, in 1987, the assailant who shot Pamela James in the head had his murder charges dropped, since his defense attorney discovered in the coroner's report that the time of James' death coincided with the time when the transplant team removed her heart. To bolster his case, the defense enlisted the aid of a neuropathologist who determined James' brain injury was of a "lower-grade" and did not preclude a chance at recovery. Since James was denied the chance of recovering, his client was not responsible for her death (Marrison 1988; Munson 2002). In none of these cases was it ever suggested that homicide law should be changed to accommodate lethal surgery, since homicide law was relatively clear, while the definition of death was not. For better or worse, two concepts of death were emerging, which had far reaching implications for medical liability and organ transplantation: *medical death* based on neurological or circulatory criteria, and *legal death* based only on circulatory criteria. Doctors and lawyers struggled to articulate a unified definition of death that would adequately represent the physical facts while serving the purposes of medicine and law, (the best example comes from Capron and Kass 1972).

was part of this solution; if anything, the rule was part of the problem that needed solving, namely, how surgeons could avoid becoming implicated in the donor's death.

It is important to acknowledge that there were determined individuals whose only concern for the donor was to avoid transgressing the law or being charged with wrongdoing. In his memoirs, Murray recalls that those who attended the International Conference on Human Kidney Transplants in 1963 were "mostly young, aggressive, and ambitious doctors" that eagerly wanted to move forward "unfettered whatever the cost" (2001, 118). He even remembers certain doctors saying, "I'm not going to wait for the medical examiner to declare the patient dead; I'm just going to take the organs." Taking on the role of "a mother hen," Murray urged a "cautious optimism" that would result in "slow and steady progress" — the "entrepreneurial zeal for rapid progress" of the young attendants had to be reined in so that their experimental practices would not fall into disrepute. Perhaps, then, the early transplanters were just being 'prudential but not moral' with the ethics of their discipline.

Worries about breaking the law do not fully explain the early transplanter's commitment to the DDR, however. There still remains the fact that no one directly lobbied for a change in homicide law or at least an exception to it, something that should have been a live option if medical pragmatism ruled the day. Norman Fost is correct when he says, "If immunity was what was sought, or assurance that there would be no liability for discontinuing life support or removing organs from a brain-dead patient, there were and are ways of achieving immunity from liability" (Fost 1983, 722–23). Statutes could have been rewritten to avoid violating the law, or new statutes could have been created to grant immunity to physicians who operated on brain-dead patients. What

explains the community's reluctance to lobby for these changes is that many transplanters were concerned with upholding the time-honored norm against medical killing, which, as they saw it, flowed from a general respect for the value of human life even in its diminished state. How many held to this view is unknown, but a sizable portion if not the majority recognized that homicide law as well as the recent formulation of the Nuremberg Code and the Declaration of Helsinki was based on something more fundamental, namely, the intrinsic worth of the human being. This concern over the worth of human life is the third and final reason that a change in the definition of death was preferred over a change in the law.

1.3.3 The intrinsic worth of the human being

The contribution of the Swedish urologist G.B. Giertz at the 1966 Ciba meeting is of particular interest, since he recognizes the conflict between the traditional inviolability-of-human-life doctrine and the expansion of legal killing in the medical context (Giertz 1966). Commenting on the situation in Sweden after the legalization of abortion in 1963, Giertz saw his country approaching a turning point where the hegemony of Christian belief was yielding to a new uncertainty about the ultimate foundations of morality. Despite the changing times, he observed that, "there is one norm, however, to which everyone seems to adhere, namely, the worth of the human being." "The inviolateness of human life," according to Giertz, "is based on the belief that every human life, even the most wretched, has a meaning" (Ibid., 140). This belief maintains its grip, not because it is rational to hold in a secular context (indeed, he thinks it is not), but because we fear that without it, "respect for the value of the human being and hence democracy is in danger" (Ibid.). The acceptance of abortion, which in his view,

terminates a human life at an early stage and deprives someone of the chance to live a long, beneficial life, lends credence to the morality of euthanasia, which presumably terminates a human life at a late stage and only deprives someone of a short life filled with misery. In either case, Giertz says we are forced to face the questions of "whether we can establish the moment when life ceases to have any human value" and whether we can draw a boundary that permits us to "disregard the obligation to protect life" (Ibid.). After sensitively considering all of these points even under the auspices of voluntary informed consent, Geirtz concludes,

> It cannot be considered consistent with good medical ethics to use a moribund person as a donor, for he has no possibility of giving permission or exercising his freedom of choice. Moreover the procedure is in conflict with the widely accepted rule of medical etiquette that personal integrity must be respected. A person dying is still a person living, and he keeps his elementary human rights up the moment when life becomes extinct (Ibid., 147).[25]

The chief purveyor of neurological criteria for death agreed. Alexandre responded,

> Dr. Giertz spoke of taking organs from a dying person. I would like to make it clear that, in my opinion, there has never been and there will never will be any question of taking organs from a dying person who has "no reasonable chance of getting better or resuming consciousness". The question is taking organs from a dead person, and the point is that I do not accept the cessation of heart beats as the indication of death. We are as much concerned with the preservation of life in a

[25] To be sure, when pressed about whether one could consent by an advanced directive to donate one's organs if one was in a state of irreversible unconsciousness, Giertz replied, "I think it would be better if we were able to take organs from living persons while they are unconscious, but with their previous permission" (Wolstenholme and O'Connor 1966). Later, however, he qualified his claim saying that he was thinking of the kidneys only, not organs like the heart. These remarks were in reference to a Stockholm case where a brain-damaged patient had a single kidney removed and then was taken off a respirator twenty-four hourss later. As stated, his remarks are ambiguous, since they occur in a context about the validity of Alexandre's tests for brain death and whether brain-death was equivalent with death or not. There is no evidence that suggests that Giertz had "higher-brain death" in mind, as if irreparable damage to one's cerebrum was sufficient for death. In fact, Giertz is aware of such an idea and deems it to be an unacceptable gerrymandering of death; he says such a view would leave the "biological and medical frame of reference " (Giertz 1966, 148). Thus, it appears that he endorsed something like Morrisey's previously mentioned protocol over Alexandre's brain-death-based protocol, because he did not agree with Alexandre that the brain-damaged patient was nothing more than "a heart-lung preparation" — a description that originates from the dissection laboratory rather than the hospital bedside (Jeffrey Paul Bishop 2011, 148–49).

> dying person as with the preservation of life in a foetus […] (Wolstenholme and O'Connor 1966, 154)

Thus, it seems that besides a concern for abiding by laws against homicide, there was a strong commitment to respecting the value and integrity of human life, a commitment that was probably a vestige of the Judeo-Christian value system that still haunts our post-Christian culture today.[26]

This quasi-religiously-informed respect for life had another application, which is all but forgotten in the DDR literature today: the total well-being of the patient could not be reduced for a medical purpose which did not in some way benefit the patient. The pedigree of this concern for the total well-being of the donor stretches back to the 1600s, when surgeons were experimenting with tooth transplantation. In 1685, Charles Allen complained that the use of human teeth from the living entailed ruining the health of the one to restore the health of the other. As he wryly observed "it is only robbing of Peter to pay Paul" (quoted in Hamilton 2012, 47). This same concern was raised by Joseph Fox in 1803, a time when tooth transplant was losing popularity. He wrote, "this operation involved in it a defect of the moral principle, as one is injured and disfigured, in order to contribute to the luxury and convenience of another" (quoted in Ibid., 48). Even as late as 1966 Italian transplanters were limited by a 1940 Civil Code that prohibited the removal of any part of the body that would irrecoverably diminish the health and integrity of the body (Cortesini 1966, 172). The recognition of this norm helps explain why both France and Italy, at the time of the Ciba meeting, had banned the removal of a single kidney

[26] Evidence for the view that the law against homicide an artifact of the belief that life is sacred is found in the legal history outlined in the U.S. Supreme Court case *Wasthington v. Glucksberg* (1997), which ruled against the constitutionality of physician assisted-suicide.

from a living patient. Not even operations like Joseph Murray's transplant between identical twins were legal in those countries, which is why Murray grasped for arguments appealing to the avoidance of "psychic trauma" — which would result from losing a loved one if one were prohibited from donating — to show that the donor's total well-being was not necessarily reduced (Murray 1964, 55).

Given these ethical commitments, it is only natural that the early transplant community became interested in a more precise and accurate definition of death. This interest is especially evident at the more cautious Ciba meeting, which focused mostly on renal transplants, and the more ambitious Cape Town Symposium, which focused exclusively on heart transplants. Reading through the minutes of both meetings shows that the skepticism of diagnosing death by neurological criteria greatly decreased in the time between them. It is often claimed by "conservative" and "liberal" critics alike that the adoption of the neurological criteria for death as outlined by the Harvard Ad Hoc Committee (Beecher, Adams, and Barger 1968) was primarily motivated by a concern for maximizing the supply of potential organ donors (Singer 1994, chap. 2 and 3; Giacomini 1997; Oderberg 2000, 87; Fost 2004, 249; Koch 2012, 59–60). This is not an unreasonable criticism as Murray was on the Committee (posing a potential conflict of interest) and the only citation the report makes is to a papal document, not any neurological study (Giacomini 1997, 1475–77). While disputes over the motives and methods of Henry Beecher and his colleagues are complex and ongoing (e.g. Bishop 2011, chap. 5; Belkin 2014), everyone acknowledged that, if valid, neurological criteria afforded the perfect opportunity to remove healthy organs at the nearest point after the time of death.

While it may be true that by twenty-first century standards, a sizable portion of the population is willing to permit vital organ procurement from those who are alive, though permanently unconscious (Siminoff, Burant, and Youngner 2004), we should not forget that these judgments are made with the knowledge that organ transplantation is a medically successful enterprise. Of course, this luxury was not available in the 1950s and 60s when the first transplants were attempted. We have this knowledge because we came to agree through the efforts of clinicians, lawyers, philosophers, theologians, and legislators that "total brain failure" signifies death (President's Council on Bioethics 2008).

It is unlikely that our progress in transplant science could have advanced as quickly as it did without the ventilator-dependent brain-dead donor whose functioning circulatory system kept transplantable organs bathed in oxygenated blood. Nonetheless, the progress of transplantation has had the ironic effect of eroding support for the DDR.

1.4 Arguments against the DDR

Despite the fact that neurological criteria are widely considered suitable for diagnosing death, two arguments against both versions of the DDR emerged from scrutinizing the motivations that the Harvard Ad Hoc Committee gave for adopting neurological criteria in the first place — specifically, the justification they offered for removing life-support from hopelessly unconscious patients and the opportunity they afforded to retrieve healthy organs from these patients. The first argument goes like this:

1. If it is true that doctors should not cause the death of their patients (i.e. kill them) for any reason, then withdrawing life-sustaining treatment upon patient request is impermissible.
2. But it is not impermissible.

3. Therefore, it is false that doctors should not cause the death of their patients for any reason.

This latest iteration of James Rachels' "bare difference" argument (Rachels 1975, 1986, 111–13) is defended by Franklin Miller, Robert Truog, and Daniel Brock (Brock 1992; Miller, Truog, and Brock 2010; Miller and Truog 2012a; See also Collins 2010). While Miller and Truog acknowledge that there is a structural difference between active euthanasia and withdrawing life-support insofar as the latter can be grounded in the common law right to bodily integrity and the former cannot (Miller and Truog 2012a, 29–30), they deny that any morally relevant difference in the doctor's action depends on the underlying pathology of the patient or on whether withdrawing life-support is an "omission," or on the death of the patient being a foreseen but unintended side-effect of withdrawing life-support. Although this argument does not directly rebut the DDR, it undercuts its ethical foundation, that is, the norm against killing patients for any reason. If to withdraw life-support is to kill, and doing so is permissible on the grounds of poor quality of life and patient autonomy, then the traditional rationale for the DDR fails (Arnold and Youngner 1993, 270; Glannon 2013). Not surprisingly, this argument is attractive to those who support voluntary active euthanasia and physician-assisted suicide — it is likewise rejected by those who do not (Miller and Truog 2012a, chap. 2; W. J. Smith 2013, 182–86).

The second brain-death-related argument against the DDR can be summarized like this:

1. If it is wrong to kill the donor, then it is impermissible to retrieve vital organs from brain-dead donors.
2. But it is permissible.
3. Therefore, it is not wrong to kill the donor.

The soundness of this argument, defended by Truog and many others, obviously depends on the claim that brain-dead donors are not really dead (Truog 1997; Fost 2004; Collins 2010; Riley 2011; Sade 2011; Miller and Truog 2012a, chap. 3; Sade and Boan 2014). Evidence adduced for this claim is that brain-dead bodies are warm to the touch, regulate temperature, heal wounds, fight infection, expel waste, and in some cases even gestate a fetus. Interestingly, however, the ablest defender of this claim and the scholar cited by every brain death critic, D. Alan Shewmon (Shewmon 1997; Shewmon 1998, 2001), does not agree that it is permissible to retrieve organs from brain-dead donors. To do so, in his view, would be to harm the donor. Furthermore, Shewmon believes that the view of harm assumed by the likes of Miller and Truog is inadequate because it is "Cartesian" in character (Shewmon 2004, 292).[27] The reason that so few follow Shewmon on this point is that the shortage in the organ supply is deemed "deplorable" (Jox 2014, 39) and any limitation on organ procurement would be "drastic" (Miller and Truog 2012a, 146), 'needless' (Nair-Collins and Miller 2016), signifying a "devotion to symbols ahead of the real interest dying patients have in transplantation" (Arnold and Youngner 1993, 292).[28]

A similar argument against the DDR emerged from the dispute over the DCD procedures that allow transplant surgery to begin two to five minutes after the time of asystole (DeVita and Snyder 1993). In the case of heart transplants, there is an alleged

[27] Robert Veatch likewise rejects the soundness of this argument, though he accepts premise (2), and rejects premise (1), because in his view we can be considered dead if we irreversibly lose our "higher" brain capacities for conscious experience (Veatch 1975, 1993). Even the famed euthanasia advocate James Rachels agrees, since in his view it is appropriate to fix "the time of death at the point at which consciousness is no longer possible" (Rachels 1986, 43). Still others defend the idea that brain-death is equivalent with death, and that we should comply with the DDR (James L. Bernat 1998; President's Council on Bioethics 2008).

[28] The idea that there might be a deeper concern about what those symbols signify and whether to have an interest in transplantation is to have an interest in a lethal enterprise is not seriously considered.

incompatibility between the act of harvesting a healthy heart from a "non-heart-beating-donor" and the act of declaring death on the basis of circulatory criteria (Veatch 2008, 2010). Thus, the argument against the DDR can be summarized like so:

1. If it is wrong to kill the donor, then it is impermissible to retrieve vital organs from non-heart-beating-donors.
2. But it is permissible.
3. Therefore, it is not wrong to kill the donor.

The soundness of this argument has been defended by Don Marquis and others on the grounds that irreversibility, which is thought to be a necessary condition for death, is not satisfied (Don Marquis 2010, 2014; Miller and Truog 2012a, chap. 5; Arnold and Youngner 1993, 267–68). Although some critics of the argument appeal to higher-brain criteria that render premise (1) false (Veatch 2010), others reject premise (2) and demand that the non-heart-beating protocol be revised if not rejected (Joffe et al. 2011; Shewmon 2010). Yet few of those who believe DCD donors are alive at the time of surgery believe that "a procedure that saves many lives ought to be halted" (Marquis 2010).[29]

These arguments find their persuasiveness in the fact that no substantial change in any of our widely-accepted practices is required to accommodate their conclusions. We would only need to change the ethical justification for these practices and implement better guidelines for informed consent. The motivation for doing this is to get around longstanding ethical norms that would render transplant surgery (and withdrawing life-support!) impermissible. As Wilkinson and Savulescu say, "The cost of preserving those

[29] Other critics deny premise (1), Tomlinson (1993) and Robertson (1999) think the concept of "irreversibility" can be satisfied if we include the donor's do-not-resuscitate order within its scope, which would make any attempt to revive the donor after asystole impermissible. In this view, the modality of impermissibility is thought to be strong enough to satisfy the "irreversibility" condition even if there is a patient in the next room who is in the same physical condition as the donor but wants to be and is able to be revived. Still, others appeal to higher-brain criteria that render premise (1) false (Veatch 2010).

norms will be the death or ongoing morbidity of many individuals," that is, those in need of a healthy organ, and "this may prompt us to consider whether those principles should be revised or rejected " (2012, 33). Similarly, Miller and Truog explain:

> Honestly facing the situation of vital organ donation poses a critical ethical choice. In order to honor the dead donor rule we can give up vital organ procurement, with the drastic consequence that many patients whose lives could be saved by organ transplantation will die. Alternatively, we can abandon the dead donor rule and justify vital organ transplantation on different grounds (2012b, 11).

Hence, critics of the DDR would have us tailor our ethical theories concerning the wrongness of killing to fit our current practices, a pattern of thought that reverses the cautious thinking behind the transplant ethics stemming from the 1960s in which practice was tailored to fit with ethics.[30]

Answering the details of the critic's arguments is another project, but for now I only want to note that, even if we grant the (controversial) first premise in each argument, they each still beg the question against the historic rationale for the DDR, that is, that we ought not to intend the death of an innocent human being. To be sure, critics justify the second premise in each argument with what I call the Disjunctive Theory of the wrongness of killing. According to this theory, it is permissible to kill someone, S, if (1) S is not (or is only minimally) harmed by death, and (2) S gives valid consent to be killed by some humane means; it is wrong to kill S if one or the other of these conditions is

[30] It is understandable why one might think this is false if one takes the development of the neurological criterion of death to be a kind of legal and moral fiction to further the ends of maximizing the organ supply and not a reliable guide to determining death. Nonetheless, those like Alexandre, who fiercely advocated for the neurological criterion, seemed quite sincere in their belief that life ought to be protected and that brain-dead bodies were dead bodies (for more details see Machado 2005). Perhaps they are wrong about brain death, but that is another matter. The point is that practice was tailored to fit with ethics, not the other way around.

unsatisfied. Yet this theory is precisely what is under dispute and so it cannot be used as a premise in an argument showing that the DDR ought to be rejected. A good example of this question-begging tactic is deployed by Rodríguez-Arias, Smith, and Lazer in their defense of lethal transplant surgery when they appeal to the moral relevance of informed consent, which to their minds, is "the main moral condition justifying voluntary euthanasia…" (Rodríguez-Arias, Smith, and Lazar 2011, 41). Yet voluntary euthanasia is prohibited for the same reason that lethal transplant surgery is according to the rationale for the DDR: the death of an innocent human being should never be intended (and death need not be intended in the case of withdrawing life-support (see Sulmasy 1998; Tollefsen 2008a for details).

Perhaps, though, the broader strategy of critics is to present a kind of *reductio ad absurdum* argument against the DDR: if the rationale behind the DDR is true, then transplant surgery is immoral; but it is not immoral, so the rationale is false and the Disjunctive Theory is rendered plausible. But this argument form is not a *reductio*; rather, it is a *modus tollens*. There is simply no formal contradiction involved unless one just assumes that lethal transplant surgery or intending death by withdrawing life-support is permissible, but that assumption is precisely under dispute. Even critics like Miller and Truog acknowledge that accepting the implication that transplant surgery, as it is currently practiced, ought to be halted is "rational" despite the "drastic" outcomes it has (Miller and Truog 2012a, 146). No doubt this implication is hard to accept. But the Disjunctive Theory has implications that are hard to accept too, since it allows for the permissibility lethal medical experimentation. Are advocates of lethal transplant surgery willing to go this far? If not, why not? If the answer is because the benefits from doing so

are not likely to follow or are too remote, then we should admit that what motivates the adoption of the Disjunctive Theory is some form of consequentialism that only adheres to the practice of informed consent because of the good outcomes it produces, not because it is the right thing to do.

A commitment to doing the right thing should compel those (like me) who accept the longstanding rationale behind the DDR to call for a restraint on our zeal to perpetuate life through organ transplant (e.g.(R. C. (Renée C. Fox 1993; R. C. Fox and Swazey 2013). That is, we should be willing to bite the bullet and curtail the practices of organ transplantation *if* the case against our current practices succeeds.[31] Yet risking this unsavory outcome is not unique to this position, since the majority of donors consistently indicate that they are willing to donate only if they are dead (DuBois and Anderson 2006).[32] If the critics have their way, vital organ transplant will become a deeply divisive practice much like abortion or euthanasia insofar as it will require physicians to kill in order to achieve their beneficent goals. While Miller and Truog are optimistic that public support for organ donation would not change for the worse if their policy recommendations were implemented, they are willing to risk a net loss in the supply of organs for the sake being honest with the public (Miller and Truog 2008, 44–45; Truog and Miller 2014, 13). On this point, at least, they agree that medical practice ought to

[31] It should be noted that I think neither the case for equating withdrawing life-support with killing nor the case against declaring death on the basis of total brain failure succeeds at all (see Jensen 2011; Lee 2016; Condic 2016; Moschella 2016 for some recent scholarship on these issues). I am currently agnostic about our DCD protocols, however.

[32] To be sure, how death is defined is crucial in that there is some support for donating organs when one criteria for "higher-brain" death is satisfied. Be that as it may, DuBois and Anderson report, "69% agreed that they would only allow donation after the patient was taken off the ventilator and his or her heart stopped beating, which would require use of a DCD protocol and reduce the number of procurable organs" (DuBois and Anderson 2006, 69).

follow sound moral principles even if they have negative effects on the organ supply, an admirable quality that other critics should imitate.

1.5 Conclusion

As we have seen the DDR is not well-defined and its purpose is sometimes poorly understood. I have argued that its essential moral core is the Don't Kill rule, and not the Death Requirement. Historically speaking, the DDR was (and still is) accepted out of an effort to comply with the law against homicide and the traditional medical norm against killing patients for any reason. Respect for the inviolability and dignity of innocent human life even at its margins was (and should be) the underlying concern, though it is unclear whether this is still the case. As organ transplantation has become a routine and commonly prescribed treatment, discontent with the rule has arisen alongside a growing dissatisfaction with our currently accepted death-criteria as well as an increasing willingness to kill patients on the basis of their autonomous choice or their poor quality of life (or both). What we see today is the opposite of what we saw in the 1960s: the tendency to rethink our laws and ethical theories concerning the wrongness of killing to befit our common medical practices. This should not be the case. Starzl's advice is as timely now as it was then: longstanding ethics recognizing the inviolateness of human life, which require physicians to provide the best care possible to their patients no matter the circumstances, should not be abandoned just because our "advancing technocracy" has made great progress. What is needed is less debate about death criteria and (*per* usual) more consistent, noncircular discussion around the question of what makes killing

wrong.[33] While this question is well worn and much discussed, a broader public consensus is needed on its answer to move the debate forward.

[33] An admirably forthright discussion of the wrongness of killing as it relates to the DDR can be found in the article by Sinnott-Armstrong and Miller (2013); for a response to their ideas see Omelianchuk (2015)

Chapter 2: What Dies in Mortal Harvesting?

Abstract: Chapter 2 begins the defense the first premise of my master argument: transplant protocols that would have us secure the donor's death would have us kill someone for their organs. Specifically, I am interested in the nature of the "someone" and the "donor's death." There are three aims of this chapter. The first is to answer the question "What are we?" with the answer, "a human organism." The second is to clarify what I mean by "death" and contend for a definition that marks the end of the biological life of a human organism, not a psychological entity distinct from a human organism. The third is to defend the neurological criterion as being sufficient for determining death.

We define death as the permanent cessation of functioning of the organism as a whole… The function of the organism as a whole means the spontaneous and innate activities carried out by the integration of all or most subsystems…

—Bernat, Culver, and Gert (1981)

I believe that the strongest justification for the brain death concept is not the integration rationale but the cessation of the organism as a whole.

—James Bernat (2014)

2.0 Why talk about death?

Any defense of the dead-donor rue (DDR) must reckon with the nature of death at some point. Since the concept of death is embedded in the rule's name, some idea of it must be referenced if the rule is to be applied. This holds true for either version of the DDR, the Death Requirement (obviously) and the Don't Kill rule. Some believe that what dies if the DDR is violated is some entity distinct from the human organism lying in the hospital bed. It is not always clear what this entity is supposed to be, but what matters is that *it* alone has moral status (i.e. it is protected by a norm against being killed), and it can disappear long before the organism disappears (which by itself, has no moral status).

Determining the death of this entity usually involves some "higher" brain criterion concerned with the capacities for consciousness or social interaction (or both). As a result, anyone who is irreversibly unconscious can be classified as dead and the otherwise healthy human organism that persists onward can be volunteered for transplant surgery. Still others believe that the DDR is violated when vital organs like the heart are taken from donors who satisfy neurological criteria. Advocates of this view contend that a human being continues to function as an organism as a whole even after all brain function is lost.

What does the controversy over the determination of death have to do with the DDR? We might be tempted to think that the rationale behind the DDR and the rationale behind the definition of death stand independently from one another. After all, one is the province of ethics and law and the other the province of metaphysics and biology — or more simplistically, one is concerned with "facts" and the other with "values." This, however, is too facile of a distinction. Death is not like photosynthesis, as if it were merely a biological curiosity; rather, death has moral aspects that involve grieving rituals, religious ceremonies, and legal changes in authority, property, and marital status. Death is bound up with our notions of personhood and when the remaining body can rightly be instrumentalized for medical and scientific purposes. The connection the DDR has with the definition of death can be found in the formulation of a sound public policy that aligns both our normative and biological concepts of death (Khushf 2010). As Khushf explains "Such policy must integrate two countervailing tendencies, with one strand of reflection pushing criteria to the far side [of death] and another strand pushing to near side [of death]" (Ibid., 347). By this he means that our respect for an individual compels

us to be confident that one has departed before we use the body for instrumental purposes, and so we determine death on very clear and unambiguous evidence (e.g. cardiopulmonary criteria, putrefaction); yet, our concern to optimize the instrumental use of the body for medical and scientific purposes compels us to confidently determine the time of death as soon as possible (hence the appeal to neurological criteria). Thus, the DDR and whole-brain death criteria constitute "two pillars," to use Khushf's words again, in a public policy meant to satisfy this twofold need for confidence in a way that is both sensitive to the norms of respect and the facts of biology. Misalignment between our normative and biological concepts of death results if we favor the normative concept at the expense of the biological concept and we adopt a higher-brain criterion, which expands the boundaries of instrumentality and contracts the boundaries of respect. Likewise, if we emphasize the biological concept at the expense of the normative concept and thereby reject any neurological criterion, the boundaries of instrumentality contract and the boundaries of respect expand, which leave us with a difficult choice: we must either curtail therapeutic practices like organ transplant, or we must make the case that certain members of the living can be rightly instrumentalized for the sake of keeping our therapeutic practices intact. While both of these options have ardent defenders, neither is attractive to policy makers.

For these reasons, I believe it is prudent to address the controversies over the definition and determination of death and offer a defense of the policy in which death is diagnosed on the basis of neurological criteria. I will argue that we have good metaphysical reasons to conceive of death as involving the end of a human organism as a whole, rather than merely the loss of a special property of that whole, which is often

called “personhood.” Along the way, I address the influential argument of D. Alan Shewmon that neurological criteria are inadequate for determining death.

2.1 What is it that dies in mortal harvesting?

Let us assume that to act in accordance with a transplant protocol that would have us secure the donor’s death is to kill someone for organs. On this there seems to be wide agreement, though unfortunately it does not take us very far. We only need to revisit the first heart transplant performed in the U.S. by Adrian Kantrowitz to see why. In that historic event, Kantrowitz used an anencephalic donor whom he submerged in freezing water to shock the heart into stopping so that death could be declared. What did he do? Did he kill someone for the sake retrieving a healthy heart? According to Shewmon and colleagues, the answer is ‘yes’ — infants with anencephaly are unquestionably living human beings (Shewmon et al. 1989). Yet by the standards of Robert Veatch and John Lizza, the answer is ‘no’ — since anencephalic babies appear to lack the capacity for conscious experience, they cannot be counted as members of the moral community or even the human community (Veatch 2010, 324; Veatch and Ross 2015, 91; Lizza 2006, 12, 2009b, 10). Hence, we must find out what it is that would die in a case of mortal harvesting.

Obviously, one could appeal to the so-called “higher-brain” criterion for death in order to reconcile Kantrowitz’s actions with the DDR. On this view, the DDR still applies, but its scope is limited to those who retain the capacity for consciousness; those who lack this capacity cannot killed by definition (Veatch 2003, 11). Traditionally, however, the DDR has been tied to a definition of death that marks the end of the biological life of a human organism, not the irreversible loss of human consciousness.

The question to be settled, then, is whether the DDR *should* be tied to this particular view of death. I contend that it should because the concepts of personhood assumed in higher-brain formulations are defective. Moreover, the DDR should be concerned with a view of death that has to do with what ceases to be, not a view that is only concerned with whether one is part of some socially constructed "moral community" or not. While it may be that our *definition* of death is socially constructed, the phenomenon of death is not; there is a real distinction between life and death that is independent of our concepts (or so I shall assume).[34] Therefore, in the coming pages, I will contend that this ontological view is best construed in biological terms, that is, *the loss of a human organism as a self-moving whole*. This is what happens in an act of mortal harvesting.

2.1.1 A *really* short history of our current definition of death

Why has the DDR been traditionally tied to a definition of death that marks the end of a human organism? Part of the answer is found in a general strategy meant to formulate a consensus position on death that could be codified in legal statutes, and be of practical use in the determination of death.[35] The most influential example of this strategy is found in an article by Alexander Capron and Leon Kass in which they develop a framework for establishing statutory definitions of death (1972). As they see it, there are four levels of abstraction in play. The first is the basic concept of death itself, which at a philosophical level is the highest sphere of abstraction. At this level, we might define death as the permanent cessation of the integration of the organism as a whole, or when personhood is irretrievably lost, or when the soul departs from the body. Common to all

[34] See Oderberg (2007, chap. 8; 2013) for my favored defense of this claim.
[35] Here I follow the sound analysis of Khushf (Khushf 2010, 332–35).

the choices is the concern over a metaphysical question: what fundamental change in reality occurs when a human being dies? The second level concerns the physiological criteria by which we determine the question of the first category: under what physiological conditions does a human being die? To be sure, there is some overlap here. It is at this level when medicine meets philosophy and the traditional cardiopulmonary standard or the neurological standard (or both) become relevant as signs of death. The President's Commission report, *Defining Death* (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1981), was instrumental in articulating the twofold statutory criteria stated in the Uniform Determination of Death of Act:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

The third and fourth levels specify operational criteria and specific tests and procedures to satisfy the conditions named in the second level. For example, an operational criterion may *merely* be the cessation of circulation (level 3), and a test for "irreversibility" would be to observe the lack of a pulse for some number of minutes (level 4).

While it was not made part of the statute, The President's Commission favored a basic concept of death involving the irreversible cessation of the integrated functioning of the organism as a whole (level 1). The reason for this was to keep our ideas of death within the empirical realm, subject to the "biological facts of universal applicability" (Ibid., 8). Evidence for death could then be determined by satisfying either neurological or cardiopulmonary criteria, both of which were taken to indicate an irreversible loss of

integrated functioning. In this way, the President's Commission sought to avoid the pitfall of giving a disjunctive definition of death that creates the impression that there are multiple definitions of death for multiple purposes (Ibid., 63). As things turned out, the document achieved something close to a consensus among legal and medical professionals. Those who favored a more psychological conception of human life were placated by the, albeit conservative, standard of what became known as "whole-brain death," while those who favored the traditional cardiopulmonary criteria could retain their long-standing and culturally significant death-declaring practices. The twofold criteria quickly became adopted in statutory law throughout the Western world. This explains why the DDR, which is parasitic on the definition of death, is tied to one that marks the end of the biological life of a human organism.

2.1.2 The case for "higher" brain death

Despite this success, the statute has been questioned ever since whole-brain death criteria were suggested. Critics rightly point out that Henry Beecher, the principal author of the influential report drafted by Harvard Ad Hoc Committee on brain death (1968), was of the view that death fundamentally involves the loss of the "individual's personality, his conscious life, his capacity for remembering, judging, reasoning, acting, enjoying, and so on," such that "when the brain no longer functions," the patient, "no longer exists as a person: he is dead" (Beecher and Dorr 1971, 121). Even more alarming was his assertion that "At whatever level we *choose* to call death, it is an arbitrary decision" (Ibid., 120 emphasis original). Hence, the common criticism that neurological criteria were proposed, not because of the biological facts they indicated, but because of

the social goals that were important to medicine at the time, specifically maximizing the supply of organs for transplant.

For these reasons, Robert Veatch first proposed his revision to the definition of death to be the loss of "that which is considered to be essentially significant to the nature of man," something he identifies with the capacity for conscious experience and social interaction (Veatch 1975, 15; see also Engelhardt 1975). His chief complaint against the whole-brain criterion is that we can never be confident that *all* of the brain's functions have ceased; what we really care about is whether the important functions have ceased, and what makes for an *important* function is socially determined. Thus, he has championed this so-called "higher brain" criterion on multiple occasions for the last four decades (Veatch 1988; 1993; 2000; 2005; 2010; 2015). Nonetheless, Veatch does not identify human persons with their cerebrums as he believes that it is possible for an artificially constructed "brain" to support the life of an individual in the future (Veatch 1993, 19). What is essential is the preservation of what it takes to be a member of the moral community: the capacities to think, feel, reason, and communicate; though curiously, he denies that what matters is a loss of "personhood" — a concept he leaves to the philosophers.

One such philosopher is John Lizza who provides a robust defense of the view that human organisms "constitute" human persons, which entails that the person an anencephalic infant might have constituted never comes to be, and those in a permanent vegetative state (PVS) are literally dead (2006, 12). While he is ontologically committed to a substantive view of persons, he agrees with Veatch that we cannot define death apart from moral and social terms. Speculating about the status of a conscious, though

artificially sustained severed human head, he writes, "Absent the identification of this being as a locus of value in a network of conscious, social relations, there would be no reason to consider the person to still be alive" (Lizza 2009c, 544). The core of his complaint with the reigning view of death is that it is beholden to a "biological paradigm" that assumes a reductive view of physicalism about human persons (Ibid., 545).

Both Veatch and Lizza are aware that judgments about what counts as death vary widely, which is why they both advocate for a "conscience clause" regarding death: it should legally be up to us to define what we think death is and if it should be determined by higher-brain, whole-brain, or cardiopulmonary criteria (these pre-ordained options that are apparently not up to us). Thus, two types of dualism are to be protected and enshrined in the law: one that allows us to distinguish ourselves from the organism to which we are related in a way that makes our organism *older* than us (person-body dualism), and one that assumes that *only* beings capable of making this distinction merit the respect that generates a norm against killing whatever it is they identify with (moral dualism). Whatever we think of such a scheme, both Veatch and Lizza insist that there are two ideas of death influencing our currently death-related practices.

2.1.3 The case against "higher" brain death

This "higher" brain proposal ought to be rejected for three reasons. First, it gets things exactly backwards by moving from socially constructed moral properties to a death-claim. By emphasizing the moral-existential concept of death at the expense of the metaphysical-biological concept, the status of *being a vital organ donor* implausibly becomes part of the definition of death. As Veatch recognizes, "Anyone who was determined to be a legitimate candidate for potential organ procurement would be, by

definition, dead" (2003, 11). Yet if we determine death this way, and on the basis of losing what is "essentially significant" to human beings, then there is no reason why we cannot classify those who have an ungoverned consciousness and cannot act or do things as dead (e.g. Sinnott-Armstrong and Miller 2013). Minimally conscious patients or even those with severe Alzheimer's disease could be classified as "dead," which is hard to believe. It is one thing to think our loved one is unrecognizable to us; it is quite another to think our loved one is no longer there at all. The mistake lies within defining death in terms of the loss of certain properties that make death *bad*; yet, the loss of these properties should not be confused with the properties that bring death about. Moreover, that which is taken to be "essentially significant" to human beings is ambiguous and a matter of cultural and subjective individual opinion that varies widely beyond just the loss of consciousness. This "slippery slope" worry has long been observed and never adequately refuted (Bernat, Culver, and Gert 1981, 391); the looseness of this view combined with a conscience clause makes death a wax nose. Consequences for transplantation would include the inevitable conflict between surgeon and donor who define death in different ways (Cochrane 2011, 149), not to mention contradictory death declarations regarding donors in exactly similar physiological states. Only a definition of death anchored in the facts of biology can keep it from being defined and applied in arbitrary or prejudiced ways.

Second, higher-brain criteria are even more counterintuitive and harder to empirically discern than our currently accepted "whole-brain" criteria. We already have trouble thinking of brain-dead bodies as dead bodies (Siminoff, Burant, and Youngner 2004). What with their beating hearts, ability to heal wounds, regulate temperature, and

even in some cases, gestate a viable fetus, we find it difficult enough to believe that these abilities do not signify life in brain-dead people (Shewmon 2001). Higher-brain criteria would further remove such life-signs as spontaneous respiration, reaction to painful stimuli, and having a sleep-wake cycle. Since the higher-brain criterion effectively hides "the living" from the standard signs of biological life, it is all the more difficult to develop a battery of reliable empirical tests that are capable of clearly indicating that an individual — which is to be identified by a capacity for consciousness — is present. This problem became acute when the American Medical Association temporarily endorsed harvesting vital organs from anencephalic infants in May of 1995 (see Glasson et al. 1995 for the justification). Six months later, the Council reconsidered its position as it became concerned with the lack of confidence in diagnosing a total absence of consciousness in such neonates (Plows 1996). The same problem confronts diagnosing PVS patients. In fact, there is some empirical evidence indicating a "preserved awareness" in those who are deemed to be in a vegetative state by conventional diagnostic tests (Cruse et al. 2011; Owen et al. 2006). Some who satisfy the tests for being in a PVS have even been found to communicate with the aid of neuro-imaging technology (Fernández-Espejo and Owen 2013; Naci and Owen 2013; Monti et al. 2010). Under the Veatch-Lizza proposal such patients could be declared dead and volunteered for organ donation provided consent was obtained from an authorized proxy. The risk of such an outcome is plainly unacceptable unless one further redefines death to include the minimally conscious, which leads to the "wax nose" problem mentioned above (Peterson et al. 2014, 29–30). The painful irony for this view is that the most reliable tests we have determining the irreversible loss of the capacity for consciousness is the currently accepted neurological criteria.

Lastly, identifying individuals with something that has a capacity for consciousness leads to the bizarre, if not absurd, result that there are two individuals residing in the same human head, each of which become aware of themselves in cases of hemispheric commissurotomy (a position accepted by Puccetti 1973, 351 oddly enough). Since each hemisphere is capable of conscious awareness, we should count two individuals that die in normal death, or at least one that would be killed if we were to successfully reattach the hemispheres (Liao 2006, 343). A better explanation of what happens in the commissurotomy case is that an organism's mental experience is fragmented. Related to this point is the issue of what exactly it is that *bears* the capacity for consciousness. There is good reason to believe it is the organism, not the person (whatever that might be); if this were not so, then non-human animals likes dogs and cats would not have the capacity for consciousness, which, if not absurd, is rather astonishing. To avoid this result, we could accept the implication that dogs and cats are not really organisms, but rather are "persons" (as suggested by Lizza 2009c, 539), though, this does nothing to increase the plausibility of the view. If both the person and the organism bear the capacity for consciousness, then there are two conscious subjects where we are, both of which experience the same things. If this is the case, there is no way for us to tell which one we might be (Olson 2001; 2009).

For these reasons, we should neither identify individuals with something that has a capacity for consciousness, nor the loss of this capacity with death.

2.2 What dies is a human organism

What are we, then? It seems easy to say, but it is not. Perhaps we are wholly material beings, or amalgams of body and soul, or an immaterial soul closely related to a

body we somehow animate.[36] Perhaps death is the end of us, or perhaps not; I will not be so bold as to rule out the possibility that we survive our death in some way. What I will contend for, however, is a broadly "biological approach" to human ontology, which takes the normal condition of human life to be within the purview of the biological sciences. From the biological point of view, those of us who are living fall under the category of organisms, a common enough observation, though admittedly lacking specificity concerning our metaphysical nature.[37] Shewmon is not far off when he says that our "philosophy of the organism" is currently underdeveloped and unable to furnish a bright line between injured organisms and non-organisms along a finely-grained spectrum of injuries (2010, 261). Nonetheless, the category of "organism" is sufficiently robust to begin a philosophical investigation into our nature with a view towards answering Shewmon's claim that a human organism *as a whole* does not depend for its existence on a functioning brain.

2.2.1 Addressing two objections to the organism view

I shall begin by addressing two objections to the idea that we are organisms to better motivate what I take organisms to be. The first objection is against the idea that organisms are essentially living beings, an idea which is thought to be incompatible with our "commonsense" view of organisms. Jeff McMahan is right when he claims that it is a matter of commonsense to view an organism undergoing a "catastrophic change" when it

[36] I leave aside the view that we might be four-dimensional space-time worms made up of temporal parts, because I am not able to make sense of a temporal part. Either temporal parts have duration or they don't. If they do, then why do they need to be invoked at all? I could just as well be a single improper temporal part on a standard eternalist view of time. If they don't have duration (=0), then how could they add up to anything temporally extended?

[37] It may be the case that we cannot exist without being an organism, or it may be that the organism cannot exist without us; I shall remain neutral on this question.

dies a normal death, but he makes a more controversial claim when he asserts that one changes from being a living organism to a dead one, i.e. we endure our death (2002, 30). This, he believes, is more acceptable than four other alternatives: (1) a brand new entity called "the corpse" comes into existence that exactly occupies the space previously occupied by the organism; (2) there was a corpse-like hunk of matter that spatially coincided with the organism before death whose persistent conditions apply after death whereas the organism's do not; (3) the property of *being an organism* is a phase of a more fundamental hunk of matter which ends at death; and finally (4) there is no such thing as "the corpse" that follows after death, just an unordered aggregate of particles. Yet despite being superior to these four alternatives, McMahan thinks it is hard to believe we could become dead organisms; he says, "unless one is a soul that bides awhile before fluttering away to its celestial abode, one will no longer be present when one's organism becomes a corpse" (Ibid.). Thus, we have no reason to believe we are organisms.

While McMahan does not think this is a decisive argument, it does motivate his brain-transplant thought-experiment, which leads him to identify us with part of the brain (which part?) that has a capacity for consciousness — a view I have already rejected.[38] Do we survive death, then, as a corpse for a while and then go out of existence at some stage of decomposition? I find this harder to believe than the view that eliminates corpses

[38] On the brain transplant thought-experiment: the idea is that if surgeons removed your cerebrum and placed it in the skull of your cerebrum-less identical twin, you would go with your cerebrum. I do not find this to be compelling, because the psychological connectedness we have with our cerebrums is not sufficient for our persistence over time. If it were, then there would be two of us if each of our cerebral hemispheres were transplanted into different heads, which is absurd: one thing cannot be identical with two different things. To his credit McMahan bites this bullet, and follows Parfit in the claim that the survival of our qualitative psychological properties is what matters, not our identity (McMahan 2002, 43; Parfit 1984, chap. 12). I leave it to the reader to decide whether this increases the plausibility of his proposal under the assumption that commonsense is to guide our evaluation of these views.

from our ontology, because it is very hard to believe that corpses are genuine wholes that amount to something more than just the sum of their (decomposing) parts. Nor should those who want to retain corpses on the list of real things in the world be bothered by the idea of a corpse coming into existence after the death of an organism, because the persistence conditions of corpses and organisms are incompatible. No organism can survive decomposition, alright, but if organisms can survive death, why should they not be able to survive decomposition? There seems to be no fundamental difference between decomposition and death, insofar as death is the onset of decomposition marked by a loss of entropy-resistant metabolism (Schrödinger 1992, chap. 6). Hence, the plausible view that an organism survives only if its metabolic processes continue without interruption such that new particles are configured and assimilated into its complex organic structure, and old ones no longer useful to the structure are jettisoned as waste (Blatti 2014; Olson 1997, 16; 2007, 28).[39] As Eric Olson explains:

> A corpse, like a marble statue, maintains its form merely by virtue of the intrinsic stability of its materials. The stability of a living thing, by contrast, is dynamic. Matter constantly flows through it, in much the same way as it flows through a fountain. A living thing maintains its form — in particular the fine biochemical structure that makes it alive — only by engaging in constant activity: repairing damage, removing waste, fighting infection, acquiring and digesting food, and so on. All of this comes to an end when the organism dies. Matter ceases to flow. The repairs stop. Decay sets in. It is this irreversible process that we call death. If ending an organism's life appears less dramatic than shutting off a fountain, that is because some of an organism's materials — its solid parts — are more stable than those of a fountain. But even its solid parts 'flow'(2004, 269).

[39] This is also thought to be a sufficient condition for organisms to exist, but I deny this for reasons below.

Since this dynamic activity is characteristic of organisms, there is no reason why the career of an organism cannot incorporate some relevant set of particles into itself as being caught up in the life of the organism, nor is there any reason to think it odd if members of that set continue to persist when that life is finished.[40] Once this entropy-resisting process ceases there is no more organism. Hence, a dead organism is just an organism "in name only" as Aristotle would say.

The second objection is against the idea that we can be classified as organisms by an appeal to the phenomenon of dicephalic twinning (Campbell and McMahan 2010; McMahan 2002, 35–39). Consider Brittany and Abigail Hensel, two women whose heads extend from a single, four-limbed body that houses two hearts, two stomachs, two gallbladders, four lungs, three kidneys, a single diaphragm, a liver, a large intestine, and a set of reproductive organs. They share a common blood stream and immune system; yet each twin has their own nervous system which senses and controls her own side of the body. As such, they appear to be two human persons caught up in the life of a single human organism; therefore, Brittany and Abigail (whom I once saw playing Frisbee[41]) cannot be classified as organisms, and since they are not fundamentally different from us, neither can we.

The argument from dicephalic twinning is usually marshalled against the view that we are *identical* with organisms, which entails that we are *essentially* organisms. That is not something I assume here, but never mind. The relevant question the argument

[40] Owen Flanagan estimates that a person who lives seventy years could have up to ten different completely replaced sets of cells that compose one's body, or in his words "ten different bodies in a lifetime" (1991, 17). Whether these bodies spatially coincide with the organism will depend on our metaphysics of composition or substance.

[41] At Bethel University circa 2008-2009. It's hard to describe how awe-inspiring this was.

raises for me is how organisms are individuated, an ongoing issue in the philosophy of biology (e.g. Bouchard and Huneman 2013). As I see it, there is no decisive reason to believe there is exactly one organism where Brittany and Abigail are, and some good reasons to believe there are two which share some of the same space with one another. First, if there is exactly one human organism where the Hensel twins are, then it is not clear how the organs within the twins are *biologically* related to them. Lee and George state the problem nicely:

> Each set of eyes, each set of ears, and so on would not belong biologically more to one girl than the other. Each of these organs would have to be a part of a single larger organism, subservient to the survival and function of this one organism. But this plainly is not the case. It is indisputable that each one *biologically* has not only her own brain, but also her own skull, eyes, ears, and many organs, while sharing many other organs (2008, 47 emphasis original).

Campbell and McMahan are eager to agree that some of the organs, to use their words, "serve only one of the two persons" (2010, 291). But in virtue of what, if not a numerically distinct organism, do they do this? They claim that, "one sibling's eyes 'belong' to her because they are the ones that she *sees* with. That is exactly what one would expect when two persons are sustained by a single organism" (Ibid, 291 emphasis original). The point appears to be that an organ belongs to a person by virtue of the fact that the person uses and benefits from the function of the organ in question. But this cannot be right. If it were, then the kidneys of the person kidnapped by the Society of Music Lovers in Judith Jarvis Thomson's famous thought experiment would 'belong' to the sickly violinist, because, after all, they are the ones with which he *filters toxins from his blood* (Thomson 1971, 48–49). This functional activity is shared between the violinist and the kidnapped person no less than it is for the Hensel twins. But clearly the kidneys

belong to the kidnapped person rather than the violinist. This is because the kidneys, along with every other organ in the kidnapped person's body are integrated into the life of the organism by virtue of the organism's coordinating activity for the sake of the organism's survival. In the case of the Hensel twins, there is overlapping integration when it comes to their kidneys, but there is no overlap when it comes to their sense organs. Hence, Brittany's eyes do not belong to Abigail (and vice versa), because they are not integrated into the coordinating activity of her organism.

Second, the fact that each twin develops not only her own head complete with a full set of sensory organs, but also her own spine and nervous system that senses and controls one side of the body — as well as her own heart, stomach, esophagus, and pair of lungs — indicates the presence of two distinct, though not completely independent entities. What else could those entities be besides numerically distinct human organisms? This hypothesis fits well with the facts of human embryology since dicephalic twinning occurs when the fission-process of monozygotic twinning fails to completely separate two embryos from one another (Kaufman 2004). It is not some genetic or epigenetic condition of a single embryonic organism. Why should we, then, count only one human organism in this case and not two? Perhaps the reason is that we assume that two human organisms cannot share some of the same physical space. We should not assume that, however, unless we are willing to suppose that, for *any* case of conjoined twinning, two brand new organisms would suddenly pop into existence if the twins were surgically separated. Thus, it is more plausible to believe that two teleological centers of life conjoin and develop together within a shared space wherein two distinct capacities for directing and regulating life-processes can be identified — and that is all that is needed to say there

are two organisms there (Liao 2006, 340–41).

Before making a more positive case for thinking of ourselves as organisms, let me pause for a moment to say that I will not be surprised if advocates of the "higher" brain view remain skeptical of these arguments. The ontology of human persons is notoriously difficult and is of limited use in guiding our policies in the hospital room. But even if our metaphysical disputes are judged to be indeterminate, then, on the basis of the precautionary principle, the best epistemic position that we can be in when determining the irreversible loss of whatever psychological property is thought to be essential to us is one that satisfies the accepted neurological criteria. Given that the whole-brain criterion is our most demanding neurological criterion, we can have a high degree of certainty that no one would be "dissected alive" after it is satisfied. The same principle also applies to our "donation after cardiac death" protocols; they should be scrutinized for the same reason: no one should be declared dead by circulatory criteria if we do not know for sure that someone has irreversibly lost their capacity for consciousness (Napier 2011). Thus, even if the organism view turns out to be false, nothing significant should change insofar as our death-declaring policies go.

2.2.2 In favor the organism view

What positive arguments are there for thinking of ourselves as organisms? Part of the problem with answering this question concerns what we take organisms to be. As a philosophic category, organisms should not be construed as being in the domain of one side in the divide between materialists and non-materialists, though it can certainly seem that way. Those who defend a biological approach to personal identity (a topic which should not be confused with human ontology) often use the term "organism"

interchangeably with the word "animal" within a materialistic framework (e.g. Olson 1997; 2015). By contrast immaterialists like Descartes take an impersonal, and implausible, "machine" view of organisms (which is aptly criticized by Nicholson 2013; 2014). A better understanding of organisms is one that places them in the category of *substance*, which materialists like Peter van Inwagen (1990; 2007, 200), hylomorphists like Patrick Toner (2011), and even dualists like Richard Swinburne (1997, 153) try to account for in terms of their vastly different ontologies. As substances, organisms are concrete particulars that endure through time, survive change, derive their unity from their internal structure or essence, possess causal powers not reducible to their parts, and are wholes that are ontologically prior to their parts such that the parts receive their identity by virtue of their place in whole.[42] Is there any argument for believing we are this sort of thing?

Here is a question worth asking: do *we* bear the capacity for biological human life? More specifically, is there a substance with which we can be identified that (1) bears the capacity for developing and functioning in the form of a human organism from the moment of conception or twining (or implantation?[43]) onward, and that (2) subsequently loses this capacity in death? If there is, then we can live the lives of human organisms and survive the loss of consciousness. Whether this substance can survive death in the form

[42] My view is at home in the Aristotelian tradition and is ably defended in contemporary form by David Braine (Braine 1992, 256–67) and J.P. Moreland (Moreland and Rae 2000, chap. 2), both of whom have had a deep influence on my thinking.

[43] See Smith and Brogaard (2003) for a defense of the implantation view; see George and Tollefsen (2008, chap. 2) for a defense of a conception/twinning view.

of something else is a question I shall leave aside.[44] A sound answer to that question will depend on whether we have the capacity to survive death, which is independent of the question I ask here: do *we* have the capacity to live a biological human life? If not, then either our biological human life derives from something that does, or we are not the sort of the thing to which biological life applies.

Suppose we are not the sort of thing to which biological life applies. Then our fundamental nature is entirely outside the purview of biology. We share nothing in common with the natural history of living things on our planet and we quite literally do not need food, water, or air to survive. That we depend on organisms to get around and do the stuff we do is just a funny contingent fact about our universe. But we really do not need these mangy creatures to get by any more than we need a car to get from Mobile to Milwaukee. Medical tests for death, then, relate to organisms insofar as we depend on them for our functioning. These tests will likely zero in on our organism's higher-brain functions, the functions upon which we happen to depend for being recognizable in this world. Despite the strangeness of this view and the fact that it inherits the epistemic problems of the higher-brain standard for death, it is very hard to understand what we could *be* on this view. All we know is that we can do stuff, though we are not strictly speaking biologically alive. Are we a kind of computer program that can be "uploaded" and "downloaded" if need be (e.g. Dennett 1978)? Then we are just bits of information, a kind of universal that is timelessly eternal and bereft of causal powers, which is contrary to our assumption that we can act and do things. If we are some sort of immaterial soul,

[44] I assume that being able to classify ourselves as organisms does not depend on our being identical with them. For a view that classifies us as organisms, but identifies us with "embodied souls" see Gilbert Meilaender (1993).

then we need some reason to believe that, in spite of having the relevant capacities to interact with the material world so as to act and do things, we do not have the relevant capacities to interact with the material world so as to live a biological human life. There is simply no principled reason why, on any plausible view of substance dualism, this should be the case.

What about the idea that our biological human life derives from something else that bears the capacity for it? This is a more interesting suggestion, because it makes use of the category of *derivative properties*.[45] For instance, a race horse crosses the finish line in a secondary, derivative sense because its nose crossed the line in a primary, non-derivative sense. In this case, the parthood relation allows us to make an appropriate derivation of the relevant property (Swinburne 1997, 145). Likewise, if we are part of a brain, we are biologically alive in a derivative sense, because the organism of which we are a part is alive in the non-derivative sense (McMahan 2002, 88–94). The same goes for "persons" who are materially constituted by an organism (Baker 2000, 99). In each case, there is an appropriate relation between us and our organism, which allows us to attribute the properties of the organism to ourselves by way of some rule of derivation.[46] We get infected if our organism gets infected, we get punched if our organism gets punched, and so on. Derivative properties abound, and sometimes they go the other way: that a human organism thinks is derived from the fact that we think. In this way, I can consistently think of myself as bearing the capacity for biological human life *in the derivative sense*.

[45] Here I am influenced by Andrew M. Bailey (2016). What follows is indebted to him.

[46] These are rarely, if ever, formally articulated. Speaking in defense of her "constitution view" Baker gives a nice example: "Roughly, (omitting reference to times), x has F *nonderivatively* iff x's having F does not depend on x's constitution relations, and x has F *derivatively* iff x's having F depends on x's having constitution relations with something that has F nonderivatively" (Baker 2008, 43).

If this is the case, then I am a human organism in the derivative sense. But consider this argument (adapted from Bailey 2016, 207–8):

1. I am a human organism in either the derivative sense, or the non-derivative sense.
2. If I am a human organism in the derivative sense, then there are two human organisms in my immediate vicinity.
3. But there is only one human organism in my immediate vicinity.
4. Therefore, I am not a human organism in the derivative sense (2, 3)
5. Therefore, I am a human organism in the non-derivative sense (1, 4).

To deny premise [1] is to opt for the claim we are not the sort of thing to which biological life applies, which is a claim we have already examined and found wanting. Premise [2] rests on the plausible assumption that something exists if something has a property; since two things end up having the property of *being a human organism* — me and the organism — there are two human organisms in the neighborhood. Premise [3] is hard to deny; all we have to do is inspect the immediate vicinity where I am and start counting: "one" is as far as we are going to get.[47]

A final objection to this argument would be to deny the initial claim that bearing the capacity for living a biological human life is sufficient for being a human organism. One could argue that a pair of human gametes or any of our somatic cells have this capacity, but neither of these is a human organism like us (see Singer and Dawson 1988; Charo 2001). Yet it is hard to understand how a pair of gametes, which only composes a mereological sum and not a genuinely unified whole, bears such a capacity. Since neither of them individually bears the capacity for living a biological human life, no new human

[47] It is worth mentioning that if we count two, we end up violating McMahan's plausible assumption that "there can be no more than one of a particular kind at a given place at a given time" (2002, 90). Perhaps this not a problem for everyone, but it is for McMahan, a point I owe to David Hershenov (2005, 33).

organism will ever come to be if they never meet. Same goes for our somatic cells: leave them to do what they normally do, and no human organism will result. The fact that these things can stand in a causal relationship to a new human organism is not sufficient for them to bear the capacity for living a biological human life. To think otherwise is to stumble over an ambiguity that fails to capture the sort of capacity I have in mind: *a capacity that is exercisable by the entity that has it*. This sort of capacity is a power within the entity to produce change within itself, and since this change presupposes the sameness of the entity that produces it, this capacity is "identity-preserving." Neither the pair of gametes, nor any of our somatic cells have this sort of capacity. Rather, they only have a "compositional capacity" which requires that they be acted upon by an external agent to effect the desired change — a change they do not survive — so that something new can come to be (See DiSilvestro 2010, 108:18–19 for a nice overview of these distinctions.). Since this new entity, which comes to be in the form of a human embryo, bears an active, identity-preserving capacity to live a biological human life, it is as good a candidate as any to be a human organism.

Therefore, a human organism dies when the DDR is violated, because when that occurs, someone loses their capacity to live a biological human life.

2.3 On determining death in human organisms

Unfortunately, determining the death of a human organism faces its own set of deep and hard metaphysical and epistemological questions. Specifically, what is needed is some mark by which we can empirically determine that the life of a human organism is finished. Given that an organism survives only if an organism's entropy-resisting metabolic processes continue without interruption, the mark should be related to when

these cease. Thus, we should agree with Miller and Truog when they assert that "death occurs at the moment when the entropy-increasing forces have irreversibly exceeded those that are resisting this process" (2012, 70). Normally, what follows this event is the beginning of the process of decay. Death, then, is thought to be marked by the "disintegration" of the organism as a whole, and, conversely, life is thought to be marked by the "integration" of the organism as a whole (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1981, 33, 77). Hence, the intuitive plausibility of the "integrative unity" model of life and death. Organ transplantation well illustrates this enduring idea that goes back to Aristotle: just as a severed hand is a hand in name only, so too is a severed heart, lung, liver, or kidney unless it is promptly reattached. If it is reattached to someone genetically distinct from the donor, immunosuppression treatment is usually needed so that the host will not reject the foreign organ and fail to integrate it into its life-sustaining work.

2.3.1 Shewmon's challenge to the "integrative unity" model

Just what the source of this "integrative unity" is, however, is a contentious question. As far as I can tell, the debate has been framed by the assumption that only organisms are able to exemplify integrative unity. For better or worse, then, the dispute over whether whole-brain death is equivalent with death has traditionally been a dispute over whether the brain is necessary for the integration of the organism as a whole. An influential interpretation of death canonized in a paper by Bernat, Culver, and Gert (1981) is that the brain is the principal source of integration — the "integrator" of the human organism, so to speak. Thus, in their description of various deaths, whether by hanging, chronic disease, or massive head injury, death always coincides with a total loss

of brain function, which brings about disintegration (Ibid., 392–93). This idea was challenged in a deep and compelling way in a series of papers by D. Alan Shewmon (1997; 1998; 2001), who persuasively argued that the source of this integration is not localizable in any one organ. While he agrees that the brain substantially *contributes* to the integration of the organism as a whole, it does not *confer* such integration on the organism as a whole. If this is right, then it seems that the brain-dead body can survive as an organism so long as its integrative unity remains intact.

It is worth examining the operational definition Shewmon gives of "integrative unity" and his criteria for determining whether it is present. Within the orthodox biological paradigm, he thinks integrative unity should be:

1. Applicable to all living organisms.
2. Reflective of the thermodynamic characteristic of life being anti-entropic.
3. Absent in corpses.
4. Internally holistic, which distinguishes organisms as wholes, rather than a mere collection of organs, tissues, and cells which require some external force to artificially unify them.
5. An all-or-nothing, non-degreed property that is either present or absent.
6. Compatible with profound disability or moribund status.
7. Compatible with being irreversibly unconscious.

Hence, Shewmon says a putative organism possesses "integrative unity" when it "*possesses at least one emergent, holistic-level property*" (2001, 461 emphasis orginal). A paradigm example is consciousness. In Shewmon's view, an isolated, yet conscious brain is an organism *as a whole*, though, of course not *a whole* organism (Ibid., 461).[48] Other examples of emergent holistic-level properties include homeostasis, elimination of waste, energy balance, regulation of temperature, wound healing, infection fighting, fetal

[48] This position was subsequently denied by Shewmon eight years later (2009a), but then reaffirmed three years after this denial (2012). I believe his uncertainty is explained by the permissiveness of his criteria, something I contend for below.

gestation, sexual maturation through puberty, proportional growth, and electrolyte balance — all things he has found in subjects diagnosed with whole-brain death (Ibid., 467–68). He even asserts that respiration and nutrition are characteristic of an integrative unity that does not depend upon the brain. By "respiration" he means the biochemical process by which oxygen and carbon dioxide transfer "across the alveolar lining of the lungs" or "the electron transport chain in the mitochondria of every cell in the body" (Ibid., 464). By "nutrition" he means "the breakdown of food into elemental forms that are either biochemically burned for energy or assimilated into the body's structure" (Ibid., 465). Since the brain has nothing do with these integrative functions, the absence of brain-function cannot signify an absence of integrative functioning in a human organism.

2.3.2 Two living things, not one: A response to Shewmon

What should we make of Shewmon's penetrating and searching criticisms of whole-brain death? I suggest that the presence of integrative unity, as Shewmon defines it, is *not* sufficient for determining whether the entity that exemplifies it after brain death is identical with the entity before brain death. Indeed, I argue that something other than an organism can exemplify Shewmon's idea of integrative unity. At first glance, this is a counter-intuitive claim. Nonetheless, I think it is plausible to construe whole-brain-death as a sign of discontinuity between an organism *as a whole*, and a *living part* of an organism, albeit one that is rather large. To maintain continuity, Shewmon's operational criterion for integrative unity needs to be permissive enough to ensure that the brain-dead body remains a human organism as whole. Unfortunately, this permissiveness yields

individuals that violate the transitivity of identity.[49] We have already seen that he allows for an isolated, yet conscious brain to be an organism as a whole; but what about the body from which it is removed? Suppose, we maintain the brainless body and it exhibits all the life-signs that Shewmon lists as being present in brain-dead bodies. By Shewmon's criterion, then, the brainless body is a human organism (a position he has defended in D. A. Shewmon 2007, 302–16). But they both cannot be *the same* organism simply because one thing cannot be numerically identical with two things, since they differ in their properties (one is in a vat, the other is not).[50] Either we go with the brain, the brainless body, or neither and that is end of us.[51] To his credit, Shewmon is aware of this implication, but he rejects the validity of fission-style thought experiments, because in the context of clinical diagnosis he says, "there is only one piece of living matter and only one person at issue" (2010, 263). This response is simply question-begging. Whether one and the same entity survives brain-death is precisely under dispute, so Shewmon cannot use this claim as a premise in an argument for the conclusion that the brain-dead body in the hospital bed is numerically identical with the organism before brain-death.[52]

---

[49] The following is influenced by Olson (2016) who responds to Shewmon's findings.

[50] I assume there is no trans-spatial relation between the isolated brain and the brainless body, because such an occult relation is not only unacceptably *ad hoc*, it is also outside the purview of biology in general. As Khushf says, "If an account of death implies that the previous organism is sustained in both parts, so I could 'turn off' either part without causing the death of the original organism, then this only shows that Shewmon did not get the correct biological concept" (2010, 353). Thus, I assume that spatial contiguity is required by a sound theory of integrative unity.

[51] Failure to understand this point besets Miller and Truog's discussion of what they call "the decapitation gambit" and the status of a decapitated chicken that runs around aimlessly for a few moments (2012, 82; 2009b, 398). Supposing that it is alive, it does not follow that the headless chicken is identical with the chicken before decapitation. Thus, they miss the point of the division scenarios put forward by Lizza (2009a, 394) and Khushf (Khushf 2010, 352–53): the issue is *not* whether the brainless body is alive or an organism of some sort, but whether the brainless entity is numerically the *same* as the one with the brain.

[52] Indeed, this premise belies his argument as he acknowledges that "there is only one '*part*' (i.e., the entire body)⋯" present before and after brain death (Shewmon 2007, 322 emphasis added). Proper parts are numerically distinct from their wholes, of course.

The permissiveness of Shewmon's criterion also transforms individual organs removed from the body and sustained by artificial means into individual organisms (Khushf 2010, 353). Suppose we remove a kidney, yet keep it "alive" in some sterile environment by perfusing it with oxygenated blood from someone with renal failure. Then, by virtue of the fact that it respires oxygen and carbon dioxide, exchanges nutrients, and creates urine, it displays "integrative functioning" and is therefore an organism. But it isn't — it's just a detached organ that is neither continuous with the organism it came from, nor the one it is hooked up to.[53] Why should we think that a brainless or headless body is any different?

Shewmon recognizes this sort of objection and responds with a what I take to be his best argument against it:

1. A functionally brain-disconnected patient on a ventilator (e.g. one suffering from a high spinal cord transection) is a severely disabled organism as a whole, not just a conscious head connected to an unintegrated collection of organs and tissues enclosed in a bag of skin.
2. The somatic effects of brain nonfunction are necessarily identical to those of brain disconnection.
3. Therefore, a patient without brain function is also a severely disabled organism as a whole (merely an unconscious one) (2010, 259).

As stated, the argument is formally invalid (Moschella 2016b, 281). Clearing away the otiose language it just says [1] The brain-disconnected patient is an organism; [2] the somatic effects below the point of disconnection are exactly similar with those found in a brain-dead patient; [3] therefore, the brain-dead patient is an organism. The premises can be true, and the conclusion false. My preferred way to make it valid goes like so:

1. The brain-disconnected patient is an organism.

[53] In a later article, Shewmon came to agree with this, because the kidney only has the "structural" and "vital-operational" wholeness of an organ, not an organism (2012, 433). We should ask however, why this same analysis cannot be applied to the brain-dead body?

2. There is no fundamental difference between the brain-disconnected patient and the brain-dead patient, because both are exactly similar in terms of their somatic functioning.
3. Therefore, the brain-dead patient is an organism.

The problem with this argument is that the "somatic effects" mentioned in premise [2] are assumed to be sufficient for wholeness, and we have just seen that they are not. Nor are they even exactly similar with one another. As Melissa Moschella explains, there is in the brain-disconnected body a "continued functioning of the ninth and tenth cranial nerves as well as continued brain-mediated hormone regulation through the blood stream" that is not found in the in the brain-dead body (2016a, n. 35).[54] Moreover, there is something deeper assumed in the first premise that makes it the case that the individual with the spinal cord transection is a unified whole. What could that be? It seems to me that what remains is a capacity for *self-directedness* or *self-movement towards the distinctively human end of rational thought and action*. It is this capacity that makes us "rational animals" — to use Aristotle's words again — and which makes us a member of the species *homo sapiens.* Evidence for the presence of this capacity in transected individuals is found in the fact that they are conscious, complete with a drive to breath as signaled by the work of the brain stem, and the fact that their circulatory system pumps one quarter of its blood every minute to the brain: "Thought," as Henry Marsh remarks, "is an energy-intensive process" (2014, 41). This is not the case with headless bodies or the infamous "TK" — a subject examined by Shewmon whose body persisted for twenty years after

[54] To be fair, Shewmon had not overlooked these functions, but he did not consider them important for his purposes, because he thinks they make no difference to the question as to whether the body below the brain is a living entity marked by somatic integration (2012, 451). This, I think, is the wrong question. We should want to know if it is the remaining part of a whole that no longer exist, or numerically identical with a whole that survives brain-death.

being diagnosed with whole-brain death at age four (Shewmon 1998). At age eighteen, an MRI revealed no intracranial blood flow (something common in brain-dead bodies), and the subsequent autopsy revealed a shrunken spherical structure in place of the brain that had calcified over time (Repertinger et al. 2006).

Still TK's body was living in some sense. This is hard to deny given the level of integrative functioning present in his body; indeed, it just sounds *wrong* to speak of TK as a "living cadaver," or a "warm-bodied corpse," or worst of all "a heart-lung preparation." That sort of language is inappropriate, if not absurd, and medical professionals would do well to discard it. The assumption that there could not be a category of biological life that makes sense of "living remains" or "humanoids" or "biological remnants" is unwarranted.[55] Gary Rosenkrantz is surely right to recognize this third intermediate category when he says:

> *[M]ulti-cellular living organisms have other living things* as *proper parts*, for instance, lung cells, sperm cells, nerve cells, and the like. However, living things of the latter sorts are insufficiently autonomous to qualify as full-fledged living organisms. That is, they are generally unable to survive for long apart from multi-cellular organisms under naturally obtaining conditions. On the other hand, some living entities of this sort can survive and reproduce *apart* from an organism under *artificial* conditions, for instance, in a tissue culture. The distinction between a living organism and such a *living possible part (LPP)* appears to be real, unconventional, and based upon the natural evolutionary causal priority of a living organism to a LPP (Rosenkrantz 2015, 307 emphasis orginal).

Thus, it is coherent to believe that there could be two "deaths" that occur in the hospital bed: the death of an organism as a whole (the human being), and the death of the living

[55] Such an assumption is made by McMahan when he says, "Those who hold that brain death is death are obliged to describe the examples cited above as cases in which *corpses* support fetal gestation, maintain immune functions and adjust them to the presence of a fetus, metabolize nutrients, excrete wastes, retain reproductive potential, and so on" (2009, 289 emphasis original).

remains.[56] This would just be the logical consequence of an argument showing that the entity before brain death is not identical with the one that exists after brain death by virtue of a loss of *wholeness*. The relevant question, then, is whether there is such an argument.

2.3.3 The relevance of an organism's "fundamental work"

With all the evidence to the contrary, I think there are some good reasons to think of a brain-dead body, as being a human organism "in name only" but not a real human organism. Thus, we need to think harder about what it means for a human organism to be an *organism as a whole*. Shewmon and other critics are right to highlight the ambiguity of this idea. What exactly does this mean? The standard view is that the "organism as a whole" refers to something more than the sum of its parts by virtue of instantiating certain "emergent" properties that are not reducible to any of its parts (Bernat 2014, 5). This, I think, is too thin of an analysis. It is precisely this appeal to "emergence" that generates the ontological permissiveness in Shewmon's work and compels him to see the brain-dead body as being an organism as a whole. The problem is this: being an "emergent" property is one that is compatible with being supervenient on, or "over and above," some combination of subvenient parts that are metaphysically *prior* to the whole. Yet we need not think of organisms this way. Assuming organisms are substances, the whole is metaphysically prior to the parts, and the parts receive their "parthood" by virtue of being unified in the appropriate way by the activity of the whole. What we have said about the capacities of the individual with a transected spinal cord offers a clue as to what

[56] This effectively neutralizes the inconsistency Shewmon alleges against those who speak of brain-dead bodies as "dying" (D. A. Shewmon 2007, 297–98).

I am on about. An *organism as a whole* is an enduring, self-directed and self-moving entity in which its parts derive their identity and function from its internal structure, and it develops by virtue of its own capacities and powers latent in itself according to an information-rich design plan intrinsic to its kind towards a distinctive end or goal.

Death, then, *is the end of the organism as a self-moving whole*, meaning there is no more entity that has this active internal structure by which its parts receive their identity and function, no more development or activity toward a kind-distinctive end by virtue of its own capacities and powers. Just as this sort of entity does not persist after decapitation, neither does it persist after brain death. A mad neurosurgeon would not do anything fundamentally different to you than a medieval executioner if he were to empty the contents of your skull — it is not as if he is merely disabling you, albeit in a severe way. Rather, he is like the utilitarian transplant surgeon who cuts you up and removes your heart and lungs without replacing them or supplementing their function. We need not presume any dubious brain-body dualism to know that this immanent, holistic, and teleological power is lost in brain death, and that any residual somatic integrative unity that this power once produced has to be artificially maintained by virtue of the transient causation supplied by a ventilator, artificial nutrition and hydration, and a lot of intensive care. By contrast, this immanent power is not lost in the ventilator-dependent patient with a spinal cord transection, the PVS patient, or the anencephalic baby. Everything in their bodies is continuously formed out of what Aristotle would call, "the source of its own production" (Phys. II 1.25-30, 192b), and while they may be disabled in severe ways,

they continue to be ordered towards their *fundamental work* as organisms: animal life with a conscious experience characterized by rational action.[57]

This talk of an organism's "fundamental work" comes from the President's Council on Bioethics lucidly written "White Paper," which functions partly as a response to Shewmon's discontent with "the integrative unity" rationale for whole-brain death (President's Council on Bioethics 2008). As they surveyed the issues of the brain-death debate, the members of the President's Council found it prudent to substitute the language of "whole-brain death" with the language of "total brain failure" so as to better reference the clinical condition that underlies the neurological test for the death. In the position the members outline for the sake of justifying the neurological criterion, they reject the integrative unity rationale as being *sufficient* for the human organism's wholeness, and replaced it with a "fundamental work" rationale. The Council explains:

> All organisms have a *needy* mode of being. Unlike inanimate objects which continue to exist through inertia and without effort, every organism persists only thanks to its own exertions. To preserve themselves, organisms *must* — and *can* and *do* — engage in commerce with the surrounding world. Their constant need for oxygenated air and nutrients is matched by their ability to satisfy that need, by engaging in certain activities, reaching out into the surrounding environment to secure the required sustenance. This is the definitive work of the organism *as an organism*. It is what an organism "does" and what distinguishes every organism from non-living. And it is what distinguishes a *living* organism from the dead body that it becomes when it dies (Ibid., 60–61emphasis original).

[57] In a recent article, Miller and Nair-Collins object to idea that brain-dead bodies only "appear to be alive" because the cause of their vital activity comes from a ventilator (Nair-Collins and Miller 2017). What they fail to consider, however, is what exactly it is that is being kept alive by the medical technology, an organism as a whole, or a very large part of an organism, something aptly noted by Moschella (2017) in her reply to their argument. The absence of a robust philosophy of an organism besets their entire analysis, which makes it unsurprising that they think that the "fundamental work" criterion invoked by the President's Council is "ad hoc" lacking an independent justification (Nair-Collins and Miller 2017, 751). On the contrary, such a criterion can be independently justified on Aristotelian grounds.

The President's Council goes on to argue that the capacities for breathing and consciousness signify the presence of three more basic capacities that are fundamental to an organism's vital work:

1. The capacity to be open to the world and receptive to stimuli and signals from the surrounding environment.
2. The capacity to act upon the world so as to obtain selectively what it needs.
3. The capacity to sense the neediness that compels the organism to act so as to obtain what it needs (Ibid., 61).

All three of these capacities are present in a human organism if *either* a spontaneous, appetitive-drive to breath is present *or* signs of consciousness are present. So, the PVS patient is in the class of human organisms; the President's Council explains:

> When a PVS patient tracks light with his or her eyes, recoils in response to pain, swallows liquid placed in the mouth, or goes to sleep and wakes up, such behaviors — although they may not indicate self-consciousness — testify to the organism's essential, vital openness to its surrounding world. An organism that behaves in such a way cannot be dead (Ibid., 61).

Likewise, anencephalic babies exhibit a drive to breath as they struggle against their fate; the fact that they have a very bleak prognosis is no reason to diagnose them as dead (Capron 1987, 6). We should also be mindful of the fact that anencephaly is often confused with hydranencephaly, another condition in which both cerebral hemispheres are absent, but the subject of which can survive for years. One clinician has observed that such individuals are "not only awake and often alert, but show responsiveness to their surroundings in the form of emotional or orienting reactions to environmental events" (Merker 2007, 79).[58] Thus, a human organism dies if both the capacity for consciousness

[58] Shewmon and colleagues rightly point out the difficulty of clearly diagnosing a true case of anencephaly from one of hydranencephaly (Shewmon et al. 1989, 1776). Getting it wrong and commencing with transplant surgery would be to ignorantly kill such children, and to do so for their organs.

and the capacity for breathing are irreversibly lost (President's Council 2008, 64–65).[59] Since the condition of total brain failure is adequate for establishing the irreversible loss of both of these capacities, it is adequate to indicate the death of a human organism.

Two objections to the Council's position are worth considering. The first comes from Miller and Nair-Collins, who believe that "The strategy of identifying some privileged functions that 'count' (ie [*sic*], perform 'vital work') as distinct from those that do not 'count' is arbitrary and ad hoc" (Nair-Collins and Miller 2017, 751). To be sure, airflow through the bronchial tree is necessary for mature human life (not so in embryos), but so is the maintenance of the blood-air barrier that allows for gas exchange. "Necessary conditions are necessary conditions," they write, "none are either privileged or discountable" (Ibid.). But surely, this is false. Just because a cause is as necessary as another does not mean that they cannot be distinguished in terms of their source and priority, that is, in terms of whether one is external and transient or internal and imminent. David Oderberg helps elucidate the concept of immanent causation:

> This is a causation that originates with an agent and terminates in that agent for the sake of its self-perfection. It is a kind of teleology, but metaphysically distinctive in what it involves. Immanent causation is not just action for a purpose, but for the agent's *own* purpose, where "own purpose" means not merely that the agent acts for a purpose it possesses, but that it acts for a purpose it possesses such that the fulfillment of the purpose contributes to the agent's self-perfection. Hence, in immanent causation, the agent is both the cause and the effect of the action, and the cause itself is directed at the effect as a perfective of the agent (2013, 213 emphasis original).

[59]Shewmon errs, therefore, when he claims the Council's position is one that asserts that the lack of breathing and consciousness is *necessary and sufficient* for death (Shewmon 2009b, 10); they are not necessary, because a brainless and breathless embryo can die by virtue of losing its capacity for cell division, which signifies the fundamental work of the embryo (Landry and Zucker 2004). What cannot be missed is that there are operations of human organisms relative to their state of development that signify the basic capacities that are fundamental to the organism's vital work.

If we could not privilege imminent causes within a thing above transient ones external to it, then we could not even say that a car battery, which cannot hold a charge and is in need of a jump, is "dead" in contrast to one that can turn the starter when prompted by the ignition key.[60] While the faulty battery might be able to circulate current so the driver can make a pit stop at the auto parts store, he dare not turn the engine off before he gets there, unless he wants to jump the battery again.[61] I do not mean to draw an analogy between human death and the death of car batteries, but to highlight an important feature of the causal story about a thing, which can in turn provide us with knowledge about the condition of a thing. That is to say, the absence of the immanent causal powers of a thing signifies a problem with the thing, and replacing the immanent powers with transient causes does not reverse the problem, but bypasses and perhaps conceals it. Moreover, spontaneous breathing signifies immanent causal activity unified by the ends of the three basic capacities fundamental to an organism's vital work mentioned above. It is not merely a series of events that involves the billowing of the chest with air, as it is with mechanical ventilation. Furthermore, the maintenance of the blood-air barrier is not necessarily a sign of an *organism's* capacity to sense the neediness that compels it to act in order to obtain what it needs, since such an activity can be maintained in headless bodies, which are not organisms at all.

The second objection comes from Shewmon who notes that the President's Council's position depends on the claim that breathing and consciousness are the *only* two functions that are individually sufficient for human life; if there were another one,

[60] Oderberg defines transient causation as follows: "If A does F to B, and A is not the same [kind] K as B (for some K), and B is not part of A, A does F to B transiently" (Ibid.).

[61] Sadly, I know this all too well from experience.

their joint absence would not be sufficient for death (2009b, 10). True enough, but what other function does he have in mind? The fact that he names none only serves to bolster the Council's position. If anyone could furnish one, it would be Shewmon, who is by far and away the most informed and respected critic of brain death there is. Perhaps, though, he figured the informed reader would just supply one from the list he has already given. Miller and Truog do just that when they assert that "fighting infections and wound healing" are indicative of the human organism's fundamental work as an organism (2009a, 189). The gestation of a fetus certainly seems to be another good candidate. Yet all these functions depend on a capacity that is more fundamental: the capacity to breathe, which is the capacity to 'reach out' into the environment and attain what it needs (oxygen) and to 'push out' into the environment and expel waste. Even if the capacity is blocked by an injury, the drive remains. As the President's Council says, "This drive is the organism's own impulse, exercised on its own behalf, and indispensable to its continued existence" (President's Council on Bioethics 2008, 62).[62] This capacity is entirely lost in total brain failure. Thus, the functions critics appeal to are definitely functions of a living thing, alright (certainly not that of a rotting corpse), but they need

[62] In their effort to debunk the President's Council's position, Shah and Miller assert that fetuses "do not have a drive to breathe" apparently because they "take in amniotic fluid in order to obtain oxygen" (2010, 550). But they fail to recognize that there is a second-order capacity the fetus has that is developing the capacity or drive to breath that is relevant. And surely the drive to breath is present at some point in womb, otherwise we would fail to breath when we are born. Perhaps they think this drive to breath appears only when one is outside the womb. That too is false, because a mature (8 month) fetus can breathe inside the womb as the following report indicates:

> Dr. Liley relates the experience of a doctor who injected an air bubble into an unborn baby's (eight months) amniotic sac in an attempt to locate the placenta on x-ray. It so happened that the air bubble cover the unborn baby's face. The moment the unborn child had air to inhale, his vocal cords became operative and his crying became audible to all present, including the physician and technical help. The mother telephoned the doctor later to report that whenever she lay down to sleep, the air bubble got over the unborn baby's face and he was crying so loudly he was keeping both her and her husband awake (Horan 1971 quoted in Schwarz 1990, 6).

not *only* be functions of an organism as a *whole*. Rather, they can just as well be the coordinated activity of a living *part* of an organism (Condic 2016), a part that could just as easily be identified with an artificially sustained headless human body.[63] This should not be altogether surprising (though it is fascinating), since it is just this sort of entity that can supply healthy vital organs for transplant.

2.4 Conclusion

Therefore, we should conclude that what dies if the DDR is violated is a human organism, something with which we can be identified, and that total brain failure is equivalent with death despite Shewmon's criticisms. As it stands, our current public policy correctly aligns our moral and biological concepts of death, and the biophilosophic justification for it is stronger than critics realize. This is not to say that our current tests or diagnosing practices are perfect. At the very least, the tragic case of Jahi McMath gives us a reason to scrutinize and refine our tests for brain death (Magnus, Wilfond, and Caplan 2014).[64] Lastly, if it turns out that I am wrong about brain death, this will do nothing to change the validity of the DDR. The fact that it would be harder to accept does not undermine the case that it should be accepted as a matter of public policy. The reason why we should forbid killing people for their organs stands independently of the brain death debate: it is a matter of respect. Or so I shall argue in the coming chapters.

[63] Some empirical evidence to suggest that this is the case is found in an experiment where researchers decapitated a pregnant sheep, sustained the headless body by artificial means, and subsequently delivered a healthy lamb (Steinberg and Hersch 1995).

[64] Shewmon has testified under oath that McMath satisfied the tests in December, 2013, but no longer does as of October, 2014.

Chapter 3: What Mortal Harvesting Is and Isn't

Abstract: Chapter 3 begins my defense of the first premise of my master argument: transplant protocols that would have us secure the donor's death would have us kill someone for their organs. There are two aims of this chapter. The first is to clarify what is meant by "transplant protocol." The second is to clarify and elaborate what I mean by "kills" and what it is to kill someone "for their organs." This will involve contending for a theory of intention that seeks to balance out our first- and third-personal perspectives with respect to determining what counts as an intentional action.

Unfortunately, the extant defences of DDR… typically do not address killing by organ procurement, but instead focus on preventing killing patients for organs.

—Christian Coons and Noah Levin

The moral character of actions depends upon two orders: what an action *is* directed to and what an action *should be* directed to.

—Steven Jensen

3.0 Introduction

It would seem obvious that someone is killed for their organs if a donor's death is secured by a transplant team. Why, then, is a detailed treatment of this claim needed? The short answer is that it can be interpreted in ways that spell trouble for the rationale behind the DDR, if not the transplant enterprise altogether. As we shall see, there are some who believe that the rationale behind the DDR only forbids being killed *by* the removal of vital organs, and that it does not forbid being killed *for* them. The burden to be shouldered, then, is to explain why this is false, and why a sound ethical justification for the DDR is concerned with killing for organs. Shouldering this burden gets us into the thicket of action theory and all the problems one might find in this difficult area of

philosophy. It should come as no surprise hat some of these problems rear their ugly heads in the DDR-related literature, yet they are often ignored, glossed over, or superficially dismissed.

Whenever we morally evaluate an action or a proposal for action, the first questions we must answer are "What is being done?" or "What is being proposed?" No sound moral evaluation can occur without an adequate understanding of the action or the proposal for action in question. Beyond this general reason, getting clear on what it means to kill someone for their organs will be helpful for two particular reasons. The first provides a principled way to rule out arguments that would have us broaden the concept of intentional killing to such an extent that we could not withdraw life-support upon a valid request in a normal end-of-life setting without intending the death of the patient. Likewise, the second provides a principled way to rule out arguments that would have us narrow the concept of intentional killing to such an extent that we could thereby surgically remove all of a patient's vital organs, not replace them, and then distribute them to others without intending the death of the patient (that is, the patient's death is just a foreseen "side-effect" of our life-saving actions). Ruling these arguments out is important, because, on the one hand, if our concept of intentional killing is too broad, one would engage in mortal harvesting if vital organs were retrieved from a dead donor whose death subsequently followed a valid request for stopping treatment. This would make the rule absurdly burdensome. On the other hand, if our concept of intentional killing is too narrow, then one could engage in mortal harvesting and claim compliance with the DDR, which would render the rule vacuous. If either case is correct, then we would have good reason to reject the rule. Yet, as I shall argue, both of these cases

depend on a faulty theory of intention that does not unify the first- and third-person perspectives with respect to what it is being intended. That is to say, the too-broad concept of intentional action grossly privileges the third-person perspective over the first, meaning that our intentions include every physical effect we know our actions can cause. By contrast, the too-narrow concept grossly privileges the first-person perspective — which is to say that our intentions are just a matter of what we choose to do, and are (predictably) chosen under an indemnifying description.

Hence, the major focus of this chapter is to get clear on what we mean by intentional killing by balancing out these competing perspectives. I shall begin by explaining what mortal harvesting is not so as to show that the DDR, contrary to what critics allege, is not excessively burdensome to the transplant enterprise. This discussion will include, among other things, criticism of the assumption that killing and causing death are equivalent as well as a principled way to distinguish killing from allowing death. Next, I shall explain what mortal harvesting is so as to show that someone is killed for their organs if the DDR is violated. The point of this discussion will be to further clarify the point of the rule and show that Double Effect cannot be used to justify mortal harvesting. I then end with some thoughts on what kind of activity transplant surgery is, and what sort of theory of intentional action we should embrace for making sense of our practices.

3.1 What mortal harvesting isn't

If it could be shown that compliance with the DDR rules out practices we have good reason to permit, then it should be rejected. This is a commonly deployed strategy for undermining the rationale for the DDR, and it comes in its strongest form from the

likes of Franklin Miller, Robert Truog, and Daniel Brock (2009; 2010). According to this strategy, merely withdrawing life-support from a deathly-ill patient constitutes intentional killing. This sort of killing should only be thought of in terms of *causing the patient's death*, and not necessarily in terms of *taking the patient's life*, which would be to cause death without the patient's consent. Hence, the strategy assumes a morally neutral account of killing so as to avoid begging normative questions against end-of-life practices in which physicians are thought to "cause death."[65] On this view, if life-support is withdrawn from donors upon their request, and they consent to donate their organs, they are *licitly* killed for their organs. Since these antecedent practices are thought to be rendered permissible by virtue of informed consent, there is nothing wrong in principle with killing people for their organs. Thus, the DDR should be abandoned. Or so the argument goes.

3.1.1 What does it mean to kill someone?

At this point, it will be helpful to answer the following question: what exactly does it mean to kill someone? The answer is not obvious, because it is not clear whether "killing" should be analyzed in terms that are normatively neutral or not. It is hard to escape normative judgments about whether or not an action is an act of killing, because there is such a strong presumption against it. Indeed, we might be tempted to prejudge a death-related act as an act of killing when in fact it is no such thing. The advantage of a normatively neutral account is that it allows us to impartially move from the identity

[65] As Miller and Truog say, "Although it is certainly possible to distinguish between authorized and unauthorized killings, the usual connotations of 'killing' suggest taking life without authorization. 'Causing death' is more naturally used in a normatively neutral sense, with no implications relating to justification or authorization" (2012, 3).

conditions of an instance of killing to a judgment about whether it is wrong or not. This appears to be the sort of project Jeff McMahan undertakes in his magisterial tome *The Ethics of Killing* (2002). Although he offers no formal definition of "kills," he does say that killing is an instance of *doing* rather than *allowing*, which involves the creation of a lethal threat, or at least, the redirection of, or a removal of a barrier to, a preexisting threat (Ibid., 236). On this interpretation, there is an act of killing, not merely an act of allowing death, if a greedy son-in-law withdraws life-support from a ventilator-dependent patient for the sake of collecting inheritance money. Why, then, would there not be an instance of killing when physicians withdraw-life support at the patient's request? According to McMahan, the answer has to do with whether the source of aid originates from those who withdraw it. To be sure, both the physicians and the son-in-law act so as to remove the aid upon which the patient's life depends, but since the physicians also acted so as to provide aid in an effort to save the patient's life and treat the underlying pathology, we have defeasible evidence to believe their act is of a different kind. In McMahan's terms, the physicians operate in the role of "Providers" while the son-in-law merely operates as a "Remover." Roughly put, anyone who acts in the capacity of a Provider *allows death* when they withdraw a continuous source of life-sustaining treatment which the Provider supplies; by contrast, Removers *kill* when they withdraw a source of aid and they do not act in the capacity of a Provider (Ibid., 380-83). While McMahan does not claim that this distinction guarantees a correct description of every action causally related to death, he does put his finger on an intuitive way to marshal defeasible evidence for distinguishing between the class of acts we normally identify as "killing" and the class of acts we

normally identify as "letting die" without making any normative assumptions about the parties involved.

Another helpful account of killing found in the medical ethics literature, comes from Daniel Sulmasy (1998). Again, the overall concern is to distinguish killing from allowing death, but instead of working out a general theory that could impartially adjudicate particular cases, Sulmasy gives a normative account of killing that is meant to account for the distinction between killing and allowing death in traditional medical ethics. In his view, *killing* is "an act in which an agent creates a new, lethal pathophysiological state with the specific intention in action of thereby causing a person's death" (Ibid., 57). By contrast, *allowing to die* is "an act in which an agent either performs an action to remove an intervention that forestalls or ameliorates a preexisting fatal condition or refrains from action that would forestall or ameliorate a preexisting fatal condition, either with the specific intention of acting that this person should die by way of that act or not so intending" (Ibid., 57-58). We should note that Sulmasy's definition of killing excludes accidental killings, because it is already presumed in medical practice that those are to be avoided. His definition of "allowing to die" is disjunctive because the traditional medico-ethical norm is one that forbids *all* proposals for killing, and permits *some*, but *not all* proposals for allowing death. For Sulmasy, being causally related to death whether by killing or withdrawing aid does not matter much; what does matter is the *manner* in which the cause of death is brought about, and how the agent's intentions relate to it. With respect to how death is brought about, the doctor *must* act so as to create a new lethal threat when killing, but when allowing death, the doctor *may or may not* make use of a preexisting threat as a means to the patient's

death. With respect to intention, the doctor *must* aim at death when killing, but when allowing death, the doctor *may or may not* aim at death. If killing is to be authorized, it must come by way of a *request* for intervention; if allowing death is to be authorized, it only needs to come by way of a *refusal* of treatment, and the right to refuse treatment is taken to be stronger than the right to request treatment. With these differences noted, traditional medical ethics presumes instances of killing to be wrong; insofar as allowing to die is concerned, there should not be a presumption for or against it since the subtleties of intention involved are harder to discern than in acts of killing — more stringent standards involving the patient's consent and the legal authority to carry out the act of withdrawing life-support must be satisfied. What the tradition leaves open, however, is what might explain the wrongness of killing or certain instances of allowing death.

We now have two relatively clear accounts of killing before us, one that is meant to be normative and one that is not, which can help us get a handle on what the DDR forbids: surgery protocols that would lead us to *secure* the donor's death. To secure someone's death is to aim at someone's death by initiating, aiding, or exercising control over a fatal sequence that leads to death.[66] Such securing could come about by creating a lethal threat independent of the donor's underlying pathology, or it could make use of the underlying pathology so as to execute an intention to bring about the donor's death. Thus, I follow Sulmasy insofar as I define killing in terms of an action that is irreducibly intentional, because that is the sort of killing that is at issue in the debate over the DDR. With that said, I depart from Sulmasy and follow McMahan in the judgment that one *can*

[66] I am indebted to Philip A. Reed for this formulation. The "fatal sequence" language comes from Philippa Foot (1984).

intentionally kill by intentionally redirecting or removing a barrier to a preexisting lethal threat. That there could be vagueness in our act-descriptions or borderline cases that are hard to adjudicate is something I will accept, as I think this problem generally applies to any action-theoretical account of killing. What is important, however, is that we have a reasonably clear idea about what it means to kill someone in a medical context.

3.1.2 Distinguishing killing from causing death

We are now in a position to evaluate the various arguments made by Miller, Truog, and Brock. Specifically, there is what might be called the No Difference argument, which we saw in Chapter 1:

1. If it is true that doctors should not cause the death of their patients for any reason, then withdrawing life-sustaining treatment upon patient request is impermissible.[67]
2. But it's not.
3. Therefore, it is false that doctors should not cause the death of their patients for any reason.

There are two ways to read this argument, one that is controversial and one that is not. If we concede along with Sulmasy that physicians contribute causally to the death of their patients when they withdraw life-support, then the argument is sound.[68] But nothing interesting follows from this unless we substitute "causes death" with "kills" as if they were equivalent act-descriptions. Clearly, this is the more controversial reading of the argument.

---

[67] I formulate premise [1] this way because Miller and Truog think that the norm against causing the patient's death applies to a doctor who does not intend the patient's death, but rather intends to honor the patient's request to stop treatment. "In these cases," they write, "the clinicians would not be intending to cause death, though the LST [life-sustaining treatment] would be stopped intentionally in response to a patient's refusal" (2012, 18). In their view, this is enough to bring physicians into conflict with the traditional norm against killing.

[68] It should be noted that thinkers like Sulmasy deny that Double Effect is necessary to justify terminating life-support; in his view, life-support only needs to be correctly judged futile or disproportionately burdensome to justify its termination (D. Sulmasy and Pellegrino 1999, 547–48).

In a notable iteration of this argument, Miller, Truog and Brock (whom I will call 'the authors') stipulate that "killing and causing death are equivalent," and go on to contend that the "routine practice of stopping life-sustaining treatment is an act of medical killing" (Miller, Truog, and Brock 2010, 303; 2009, 456). Evidence for this judgment is adduced from comparing two cases, one of which I will call Injured Man and the other, Murder Victim:

> *Injured Man:* A middle-aged man suffers an injury that leaves him in a quadriplegic state and dependent on a ventilator. After living in this condition for a few years, he judges life to be not worth living, and requests that life-support be withdrawn. After his request is deemed valid and his physicians comply, he dies twenty-minutes after life-support is withdrawn.
>
> *Murder Victim*: A middle-aged man suffers an injury that leaves him in a quadriplegic state and dependent on a ventilator. Unlike the Injured Man, he wants to go on living. But a greedy son-in-law wants his estate and when the opportunity presents itself, he withdraws life-support. The man dies 20 minutes later.

The authors think that we cannot sensibly claim that the Murder Victim was killed, while the Injured man was not killed, but merely allowed to die. Nor do they say that both were allowed to die, because in both cases, "What explains his death following withdrawal of mechanical ventilation is not his spinal cord injury but the act of turning off the ventilator" (2010, 304). The only morally relevant difference between the two cases is consent; "but," they assert, "this ethical and legal difference has nothing to do with the cause of the patient's death, which is the same in both cases" (Ibid.). Elsewhere, Miller and Truog (sans Brock) say they do not presuppose any theory of causation in general, but only a commonsense notion that is able to pick out interventions that a "make the

difference" in an otherwise normal sequence of events.[69] They write,

> Causes are events or circumstances that *make the difference* in explaining a particular occurrence. Assuming that when a patient is on life support, the patient normally will continue to live for some period of time (though may be vulnerable to dying despite LST [life-sustaining treatment]), then withdrawing life support is an intervention that brings about death, when death, in fact, ensues after the withdrawal occurs. The withdrawal makes the difference between continued living and death occurring at a given time subsequent to the withdrawal (Miller and Truog 2012a, 6 emphasis orginal).

All three authors are agreed: "Withdrawing life-sustaining treatment, when followed shortly by the patient's death, is a life-terminating intervention," and the "proximate cause" of death (Miller, Truog, and Brock 2009, 456).

Before I list four problems with this argument, let me register a complaint with this "makes the difference" account of causation. As we know from tort law and negligence cases, what "makes the difference" in an actionable event involves an agent operating in as a sphere of responsibility with specific duties and goals, not just mere causal activity. Indeed, it is difficult if not impossible to give a non-normative account of human action, because human agents operate within a sphere of responsibility constituted by duties and goals. This sphere of responsibility gives us reason to reject the equivalence between "causes death" and "kills" straightaway. "Causing death" — whatever that might mean — is only necessary and not sufficient for killing, because "difference-making" causes can be direct or indirect, and one does not necessarily kill if one indirectly causes death. Think of a sheriff who is the fastest draw in the West and will win his duel with a cocky outlaw at high noon, provided that his gun functions properly. In preparation for

[69] Though to be sure, all three authors agree that they are assuming the "commonsense" notion as articulated by Hart and Honoré (Hart and Honoré 1985).

the duel, the sheriff has his gun serviced by the local gunsmith (so that it will function properly), who, through some tragic mishap, renders faulty service. At high noon, the sheriff's gun jams and the outlaw shoots him dead. Since in the 'normal course of events' this would not have happened, we can say that the gunsmith caused the sheriff's death, because his faulty repair *made the difference* to the outcome.[70] Nevertheless, he did not kill him — the outlaw did that (this example belongs to Katz 1970, 253 n31; cited in Wierzbicka 1975, 491).

Second, the authors beg the question against McMahan's supposedly non-normative account of the distinction between killing and letting die. On his account, it can be coherently maintained that the Injured Man was allowed to die, and that the Murder Victim was killed. This is because the physicians removed a continuous source of aid they had initially supplied in the Injured Man case, whereas the son-in-law removes a source of aid he had never supplied in the Murder Victim case. This does not mean that what the doctors did was okay, or that it is false that they 'caused death' in some sense. As we saw from Sulmasy's account, it is hard to believe that A is not causally responsible for B's death if A allows B to die by virtue of removing life-support. Yet by failing to recognize the Remover/Provider distinction and by equating causing death with killing the authors are left with the problem McMahan is trying to solve. That is, it leaves them with little ground to affirm the intuitive judgment that the famed violinist of Judith Jarvis Thomson's "Defense of Abortion" (1971) need not be killed, but merely allowed to die if the one who is kidnapped and hooked up to the violinist (so as to provide the means of

[70] The "difference-from-normal-course-of-events" view of causation is precisely taken to be the commonsense of causation as rigorously outlined by Hart and Honoré, which they apply to omissions, particularly the case of the gardener who fails to water the flowers (Hart and Honoré 1985, 38).

life-support) unhooks herself from him. The position of the authors implies that the kidnapped person kills if she unhooks. To be sure, it is possible for the kidnapped person to intend the violinist's death by unhooking herself from him. Yet, the point of Thomson's argument is to show that it is also possible for the kidnapped person to refrain from providing treatment for a good reason and thereby allow the violinist's death as a side-effect of her action.[71] This much is not even possible on the authors' argument. Their fundamental mistake lies in analyzing the killing/letting die distinction in terms of the causing/not causing distinction (Jensen 2011, 176).

Third, by virtue of invoking talk of causation the authors inherit an ambiguity that once clarified, either renders their account trivial or irreducibly normative, both of which are contrary to their intentions. Specifically, they fail to adequately distinguish between *the causes of history* and *causes of explanation*. The causes of history are the individual elements in a set of elements which are jointly sufficient for the effect. Deciphering the scope of the causal history can be tricky, but we can reasonably do so through a normatively neutral scientific method. By contrast, the causes of explanation are those elements we pick out from a causal history that "make the difference" according to some explanation that is relative to our interest in understanding why some event occurs (see Lewis 1986 for a nice overview of this distinction). Determining the causes of explanation is generally a pragmatic exercise in which we make assumptions about what is 'normally' the case and what is at stake for us in the explanation. When we say "Y occurs by virtue of X" in the causal sense, we highlight X as a salient part of the causal

[71] Whether this is analogous with abortion is another a matter.

history behind Y's occurrence. What determines salience? John Greco identifies two factors: (1) the elements that are *abnormal* in the causal history, and (2) our *interests* and *purposes* in formulating an explanation (Greco 2002, 310). A useful shorthand for distinguishing the causes of history from the causes of explanation can be put like this: an element in the causal history of an effect is *a* cause of the effect, whereas an element named as the cause of explanation for an effect is *the* cause of the effect.[72]

Once this distinction is made, we can see that the authors' argument is not well-served by either of them. As we have seen, defenders of the traditional distinction of killing and letting die (like Sulmasy) readily agree that physicians are *a* cause of the patient's death when they withdraw life-support. This renders the No Difference argument trivial, which is contrary to the authors' assumptions. In order to make it non-trivial, they have to single out the physician's causal contribution as *the* cause of death. But to do this, they have to make judgments about what is salient, which pushes them beyond the neutrality their project. To see why, let us suppose Ann is chopping firewood and the axe-head works loose and flies off the handle, hitting Brody in the head. Brody crumples to the ground unconscious, but does not immediately die; the resulting head injury causes him to breath irregularly, though he will continue to live if he receives assistance. Carly springs into action and performs mouth-to-mouth resuscitation on Brody for a full hour while Ann calls for help. Sadly, there is no help to be found because they are far out in the country. Exhausted and frustrated, Carly gives up hope for Brody, and ceases breathing air into his lungs. Brody's breathing becomes irregular and it finally

[72] I was alerted to these terms in Birch (Birch 2013, 431–32), though he deploys them differently.

stops, which leads to cardiac arrest shortly thereafter. What caused Brody's death? We might suggest a number of things, like brain damage, or the loss of circulation, or to be more commonsensical, the fatal injury from the axe head. All of these factor into a causal story about Brody's death. Of course, Brody's death would have occurred at an earlier time than it did had not Carly intervened. Thus, Carly's ceasing to resuscitate Brody can be factored into the account as *a* cause too. But it makes no sense to say that Carly is *the* cause of Brody's death, because her actions do not best explain why he dies. This is because she neither initiated, nor aided unto completion the sequence of events that led to his death — rather, she merely delayed them. To be sure, if all we are interested in is explaining the *timing* of Brody's death, then our focus shifts immediately to Carly as to what might explain *the* cause of death at that particular time.

The authors seem to sense this problem, which is why it is no accident that they frame their causal explanations in terms of the timing of death. They write,

> To be sure, [the] patient's inability to breathe on his own is part of the causal explanation for why he dies after his ventilator is stopped. But withdrawing the ventilator causes his death precisely because had it not been withdrawn he would continue living, *likely for a substantial period of time*. The withdrawal of the ventilator accounts for the patient *dying at the time* and in the manner that he does. It is difficult to see how it can reasonably be denied that stopping the ventilator causes this patient's death (Miller, Truog, and Brock 2010, 304 emphasis added).

Difficult, indeed. Nonetheless, this is not a decisive argument. We might also think that the patient's request "makes a difference" too, because if he had not made it, the doctors would not have terminated life-support and he would have continued living. If the authors are right, then it should be just as difficult to deny that requesting the withdrawal of life-

support "causes" the patient's death.[73] This, however, would not serve their purposes in showing that withdrawing life-support is *the* cause of the death, which is essential to their broader claim: that withdrawing life-support is a form of medical killing. Widening the scope of concern to include things like the patient's request or the underlying pathology — which is the reason why the patient is on life-support in the first place and why he wants to die — only complicates the picture.

To their credit, Miller and Truog (sans Brock) acknowledge this complexity in their helpful book *Death, Dying, and Organ Transplantation* (2012). They even sense the ambiguity between the causes of history and the causes of explanation in this particularly interesting paragraph:

> Consider the following example. A sailboat springs a leak and begins to take on water. The sailor turns on a battery-operated pump that keeps the boat from filling up with water. The battery, however, becomes drained and the pump stops working. The boat begins to fill up with water. What caused this outcome? Obviously, it wouldn't have happened if the boat hadn't sprung a leak. But it also wouldn't have happened if the pump had continued to operate. Thus, it is natural to say that the stopping of the pump (along with the leak) caused the boat to fill up with water. At the least, we would note the battery failure as contributing causally to, or being a partial cause of, the outcome. If the stopping of the pump by battery failure causes the boat to fill up with water, then certainly the same outcome would be caused if the sailor, for some reason, turned off the pump. Once a mechanical device intervenes to arrest a natural process, the stopping of the device causally explains, at least in part, the outcome. If not *the* cause, it is a cause. It is difficult to see why the same account should not apply to stopping LST [life-sustaining treatment], such as mechanical ventilation (2012, 6 emphasis original).

Here they are aware of the difficulty in saying the pump's stopping was *the* cause of the boat's sinking. To be sure, it would be much easier to single out the faulty pump if we were only interested in explaining why the boat sunk at the time it did, but that is not all

[73] Note the unhappy proliferation of causal over-determination in their "common sense" account.

we are interested in. Once we start explaining the occurrence of the event *per se*, the scope of causal history necessarily broadens to include things like the condition of the hull or whatever it was that brought about the leak in the first place. So too with explaining why a patient dies when life-support is withdrawn. And as we have seen, the recognition that stopping life-support is *a* cause is no problem for traditional medical ethics.

In fact, Miller and Truog's rejection of any appeal to the underlying condition as *the* cause of death betrays their commitment to a non-normative account of "causing death" that is free of moral bias (something they hold against the traditional view). This is evident in the thought experiment they marshal in defense of attributing of causal responsibility to physicians. They write,

> Consider the following case. A careless hiker throws a lit cigarette into the woods, causing a forest fire. The act wouldn't have caused the fire if the woods were wet, rather than extremely dry; nor would the fire have spread widely if the wind wasn't blowing. But neither of these underlying conditions negates the common-sense judgment that throwing the lit cigarette into the woods caused the forest fire. We don't say that the dry conditions or the wind caused the forest fire. The patient's underlying medical condition is (to some extent) analogous to these underlying conditions necessary for the fire to start and spread (Ibid., 10).

While this analogy might befit a scenario in which the doctor is indifferent to harming the patient, it does not befit the normal circumstances under which a caring doctor withdraws life-support. Here's one that does: a raging forest fire is encroaching on a house, but it is being held back by firefighters. After fighting it off as best they can for a while, they realize their efforts are futile even if they could continue delaying the fire's encroachment for some time. They decide to turn off their hoses and vacate the premises, which allows the fire to overtake and consume the house. While it may be true that the retreat of the

fire fighters contributes causally to the destruction of the house, it makes no sense to say that their retreat is *the* cause of the house's destruction.

The fourth problem with their argument is that withdrawing-life support is not necessarily even *a* cause of death. There are notable cases in which life-support is withdrawn and the patient goes on living, the most famous being that of Karen Ann Quinlan (Kass 2002, 36). Other cases are less well-known, but no less dramatic. Consider a ventilator-dependent patient who indicates no sign of an effort to breathe for a week; when the ventilator is finally withdrawn, the patient subsequently gasps for air, compelling the physicians into life-preserving action.[74] In this case, a deep drive to breath emerges when the body is being deprived of oxygen. Since withdrawing the ventilator "makes the difference" in bringing about the effort to breath, it would clearly be wrong to say that withdrawing life-support "causes death" — indeed, we might even think it brings about a greater degree of well-working within the organism as a whole. Obviously, this undermines the authors' argument, which is why they routinely build the occurrence of the patient's death into all the cases they examine. But it is one thing to shoulder the burden of explaining why death comes about, *if it comes about*, when life-support is withdrawn; it is quite another to assert that death *will inevitably come about* when life-support is withdrawn, which is what we might reasonably interpret "causes death" to mean. If the authors are to successfully defend the claim that physicians kill their patients by means of withdrawing life-support from them, they would be better served by utilizing language that gets past the difficulties that beset talk of causation.

[74] This experience was relayed to me personally by a physician.

For these reasons, we should reject the claim that transplant protocols that involve withdrawing life-support from donors *must* involve killing someone for their organs. This is not to say that donors could never be killed in this way, or that moral qualms of over certain protocols that involve the transplant team in withdrawing life-support are unjustified. Perhaps those teams are not acting in the capacity of Providers or they are intending the donor's death as means to their ends. However we adjudicate these protocols, *the manner* in which death is caused will be at issue, not *that* death is caused.

3.2 Mortal harvesting is killing for organs

So much for the strategy that purports to show that killing must be involved in ordinary procurement procedures by virtue of broadening our concept of intentional killing. But what about a strategy that narrows it? This is a less prominent strategy, but it is sometimes disputed that mortal harvesting involves killing for organs. Christian Coons and Noah Levin remind us that someone is not necessarily killed for their organs if surgeons simply remove (and do not replace) vital organs from a living person, a trivial truth if that is all that is being done (Coons and Levin 2011, 241–42). More controversial is their claim that the DDR, which they formulate solely in terms of the Death Requirement, only forbids killing *by* having one's organs removed, not killing *for* one's organs (Ibid., 242). They consider a case where: (1) the time of a person's termination is fixed; (2) the person autonomously requests to be killed *by* the surgical removal of vital organs, but does not choose this method of killing *for* the sake of organ removal; and (3) the act of surgical organ removal is no more harmful to the person than alternative forms of termination (Ibid., 237). To illustrate, they imagine a killer who gains access to a magical killing machine that will terminate its victim fifteen minutes from the time it is

turned on. Since it can kill by any method, it would not be wrong to honor the request of the victim to tell the machine to kill by surgical organ removal as opposed to other forms of killing — being crushed by a giant iron ball, for example. As they see it, the killer would be permitted, if not obligated, to program the machine to kill by surgical organ removal, and that this would constitute a justified violation of the DDR, which, in their view says "multiple vital organs should only be taken from dead patients" (Ibid., 236).[75] Despite their acknowledgement that the "killing machine" thought experiment is fanciful, they argue that the relevant conditions can be satisfied in contexts where voluntary active euthanasia and capital punishment are permitted. In these contexts, choosing to be killed by surgical organ removal has at least a neutral or even beneficial effect, because a measure of the victim's autonomy is respected and the lives of those who might receive one of the leftover organs are preserved. Thus, they conclude that the DDR does not strictly prohibit killing people *for* their organs, but only killing *by* organ removal. This, they think, renders the DDR arbitrary and unmotivated.

Their argument fails for two reasons. First, they offer no reason why the DDR should be formulated exclusively in terms of the Death Requirement. As we saw in Chapter One, there are good reasons to interpret and formulate the rule in terms of the Don't Kill rule, which can be stated conditionally: if killing the donor is involved to get vital organs, then we ought not do it. Why they insist on such a narrow interpretation of the rule goes unexplained. Second, the fact that one could consent to be killed *by* the

[75] Note the oddness of thinking that the killer would be obligated to do this for the victim while ignoring the question as to whether the killer is obligated not to kill the victim. The authors never stipulate or assume that the killer is free from this obligation. The most charitable reading of their argument, which will henceforth be assumed, is one that makes this assumption.

surgical removal of organs, but not *for* the sake of their removal is simply irrelevant in the context of organ donation, the context to which the DDR applies. In that context, no donor is indifferent to the good of having one's organs harvested for the sake of helping others, and no transplant team is indifferent to the good of harvesting healthy organs for transplant. Nor is it clear how someone who is subjected to the whims of a maniac that controls a magical killing machine could be considered a "donor" in any relevant sense. In any event, for those who intend to donate, the choice-worthiness of death by surgical organ removal depends on being able to choose it for the sake of supplying healthy organs. Apart from the context of organ donation, the only plausible reason for choosing death by surgical organ removal would be for the sake of avoiding a more painful death (assuming the procedure is painless). But this completely evaporates in a context where voluntary active euthanasia is allowed (assuming the practice is painless), a context which is supposed to simulate the conditions of the "killing machine" thought experiment. The same can be said of killing in capital punishment, which, at least in modern societies, aims at applying the most humane form of killing possible. Undoubtedly, it is possible for one to choose death by surgical organ removal, but not intend, though perhaps foresee that one's organs would be used for transplant. We can always tell some macabre story about how dying by surgical organ removal would be a better way to go than suffering some other grisly fate. Nevertheless, it does not follow from the fact that the DDR fails to sensibly forbid killing people for purposes unrelated to attaining healthy organs that it fails to sensibly forbid killing people for their organs in the context of organ donation.

Nor is the rule redundant, as Coons and Levin allege (Ibid., 243), as if it were like

a rule that prohibited killing without anesthesia; indeed, being killed without anesthesia is not choiceworthy. This is not the case with "organ donation euthanasia" because it is thought that the benefits of donation, to the donor and the recipients, provide the strongest case for the practice of euthanasia in general (Wilkinson and Savulescu 2012, 41). This explains why exceptions to the ban on killing patients for any reason are sometimes entertained and advanced by those who otherwise reject euthanasia and physician-assisted suicide. For example, James Bernat, who is a defender of the DDR (2013) and an opponent of physician-assisted suicide (1996), thinks that if it could be shown that a currently accepted donation-after-circulatory-death (DCD) protocol violates the DDR, it would be a "justified exception" to it (2006, 128). Yet this is a mistake on Bernat's part, because it is simply inconsistent with the norm against intentionally killing patients for any reason in general, and for their organs in particular, which, as Bernat correctly notes, is "the *raison d'etre*" behind the DDR (2006, 129).

3.2.1 Could Double Effect justify mortal harvesting?

One way to deny that intentional killing is involved in mortal harvesting is to narrow the concept of intentional killing. We might exploit the aforementioned distinction between what is intended and what is foreseen, but not intended, which is essential to Double Effect, a procedural rule of practical reasoning that permits the bad effects of an action only if they are *side-effects* of the action, that is, effects which are foreseen, but not intended. Roughly, Double Effect permits actions that cause at least two effects, a good one and a bad one, if the following criteria are satisfied: (1) the act is aimed only at the good effect; (2) the bad effect is unavoidable if the good effect is to be achieved; (3) the bad effect is not a means to the good effect; and (4) the good effect is

proportionate to the bad effect (Harris 2012, 85). While there are different ways of formulating the rule of Double Effect (e.g. Marquis 1991), the common purpose of each is to provide justification for causing a bad effect that is consistent with morality. Traditionally, Double Effect is utilized in normative systems of ethics that are committed to moral absolutes (Shafer-Landau 2015, 223–27); thus, it is relevant to my argument as I am defending an absolute prohibition on killing people for their organs.

Surprisingly, there are some who think Double Effect is able to justify mortal harvesting. Noah Levin suggests just such a strategy when he writes:

> Such a defense could work as follows: DCD donors are patients that are candidates for organ procurement. Whether they are dead is irrelevant to the procedure. Doctors are permitted to procure vital organs from such patients. This might have the consequence of terminating the patient, but this is an unnecessary concern. The goal of the procedure was to procure organs and doing so in this situation is morally permissible. If they are killed, this is merely just an unintended consequence, and if it is bad, then it is acceptable. This defense is an example of the "doctrine of double effect." Although it might be impermissible to kill a patient under normal circumstances, this harm is acceptable because it is a consequence of the decidedly good action of procuring organs (2013, 93).

This makes little sense. If doctors are already permitted to engage in DCD-style mortal harvesting on independent grounds, then invoking Double Effect is redundant. Nor is the death of the donor an "unnecessary concern" for those who deploy Double Effect, because it must be proportional to the good effect. In any event, Levin is only floating this as a possible justification for mortal harvesting, though he does not seem to take it too seriously.[76]

Still there are better appeals to Double Effect that are worth examining. The act-

[76] David DeGrazia also suggests that Double Effect could be used to justify taking organs from brain-dead patients (he contends that such patients are alive), though it too seems doubtful that he takes this strategy very seriously as he merely suggests it in a short footnote in his widely cited *Human Identity and Bioethics* (2005, 154 n85).

utilitarian philosopher Torbjörn Tännsjö thinks that those who are *not* committed to Kant's Categorical Imperative, yet are committed to the sanctity of human life (i.e. innocent human life must not be taken) and the rule of Double Effect, "must concur" with the judgment that it would not be wrong to cut up and distribute the organs of an unsuspecting patient provided that no one finds out about it (Tännsjö 2015, 205).[77] How is the bad effect of the patient's death not a means to the good effect of organ procurement? "When the doctor cuts up the patient," Tännsjö writes, "the intention need not be to kill him. The idea is just to use his organs to save lives. If the doctor could take the organs without killing the patient, then he would do so" (Ibid., 205). To justify her intention, the surgeon can deploy a counterfactual test to show that the death of the patient need not be part of her goals. Roughly, the counterfactual test goes like this: if one were able to choose a course of action that would achieve one's goals without the bad effect, and if one would thereby so choose, then one does not intend the bad effect; but if one knowingly refrains from choosing that course of action, then one intends the bad effect. Therefore, if this theory of intention is correct, it need not be the case that a transplant team *intentionally* kills someone for their organs while following a protocol that will lead them to secure the donor's death.

3.2.2 Double Effect cannot justify mortal harvesting

The problem with this argument is that the counterfactual test is insufficient to distinguish between what we intend as a means to an end, and what we foresee, but do not intend as a side-effect. While it may reveal something interesting about our attitudes

[77] Tännsjö assumes without argument that Kant's principle that we must always treat someone as an end, and never as a mere means is not contained in the sanctity of human life doctrine or Double Effect reasoning. This is unwarranted assumption, but I will grant it for the sake of argument.

towards the bad effect if we would not will it as *an end* in some possible world, it does not follow that we do not will it *as a means* to an end in the actual world. The problem is that the test confuses what we value with what we intend, which in turn, produces the fallacious consequence that our intentions are only concerned with our ends. Since what we ultimately value is determined by our end, and since the means to the end only have instrumental value and therefore can be dispensed with if they fail to achieve the end, it is mistakenly thought that we do not intend the means if we would be willing to do something else to achieve our end (Di Nucci 2014, 34). There is, however, no reason to believe that what we intend is exclusively defined by the ends to which we aim. The fact is the means are intended, since they are chosen for the sake of bringing about the end. What one could choose in another possible world does not determine what is intended in the actual world.

Despite the failure of the counterfactual test of intention, Tännsjö could insist that the surgeon need not intend the death of the unsuspecting patient if determining one's intention is only a matter of identifying the descriptions under which a proposal for action is chosen. Interestingly enough, this view of intention is defended by some very reputable sanctity-of-life advocates. In particular, John Finnis, Germain Grisez, and Joseph Boyle (2001) defend an account of intention that is purely "first-personal," meaning that an agent's intentions are *only* constituted by the agent's reasons for choosing what to do (or, more technically, by the agent's reasons for choosing a *nested sequence* of things to do). On this view, what one intends is just a function of what one chooses to do, and what one chooses to do is identified by the description under which one's proposal for action is selected. As Christopher Tollefsen helpfully explains, "What the agent intends is thus a

matter of this proposal, and nothing else: facts about the world, of causality, or of the proximity of one effect to another do not determine agent's intention…" (2008, 9). Thus, to morally evaluate an agent's action one must identify the act-description in question *from the agent's perspective* and not from the perspective of an observer (Finnis, Grisez, and Boyle 2001, 12).[78] For example, under the circumstances in which the death of a mother and her unborn child is unavoidable due to complications in delivery, Finnis, Grisez, and Boyle believe it is possible for a doctor to perform a craniotomy without intending the child's death — "even one involving emptying the baby's skull," as they daringly put it (2001, 28).[79] How is this possible? By *truthfully* articulating what is included and not included in one's proposal for action. If one's reason for acting is "to save the life of the mother," and to do that, one chooses "to remove the child from the womb," and to do that, one chooses "to change the dimensions of the child's skull," and to do that, one chooses "to empty the contents of the skull and collapse it," then it does not follow that one chooses to kill the child, because the child's death appears nowhere in the means chosen in the agent's deliberation. Indeed, this course of action could be adopted for the same reasons if the child died before the operation, so it need not be the case that the doctor intends the child's death. We can construct a parallel case for Tännsjö's purposes: if the surgeon's reason for acting is "to save the lives of the five,"

[78] We might favor this view of intention, because it avoids (1) the problems posed by Chisholm's (1970) "diffusiveness" and "division" principles in our theory of action, (2) the dubiousness of the "act-omission" distinction, and (3) the problematic presence of "moral luck" in our practices of attributing moral responsibility to people (Tollefsen 2006, 454–58). We might object to this view, however, because it makes morality only a matter of the heart, and never a matter of events or processes that occur in the physical world (see Jennifer A. Frey forthcoming).

[79] A craniotomy in this context is the operation of cutting or crushing the child's head to effect delivery.

and to do that, she chooses "to change the location of these organs to those locations," and to do that, she chooses "to cut up the patient and distribute the relevant organs accordingly," then it does not follow that she chooses to kill the patient, because the patient's death appears nowhere as a chosen means in the agent's deliberation. Indeed, this course of action could be adopted for the same reasons even if the patient suddenly died before the operation, so it need not be the case that the doctor intends the patient's death. That this would be wrong because the patient does not consent to the operation is a Kantian concern, which is something we are setting aside for the moment. Thus, Tännsjö can preserve Double Effect's intend-foresee distinction in a way that shows how one could engage in mortal harvesting without intending anyone's death.

Or can he? It is not clear to me whether those who hold to a purely first-person account of intention would agree that the surgeon need not intend the death of the unsuspecting patient. After all, defenders of this account do expect agents to be rational, and that they "must believe there to be some relationship between what is chosen as the means and what is desired as the end state of affairs" (Tollefsen 2006, 453). It would be odd if the surgeon genuinely believed that the death of the unsuspecting patient did not contribute to saving the five, because it would seem, from the surgeon's point of view, that the removal every vital organ from the patient would entail the patient's death. Yet defenders of this view of intention, like Lawrence Masek, contend that "an effect is intended (or part of the agent's plan) if and only if the agent *A* has the effect as an end or believes that it is a state of affairs in the causal sequence that will result in *A*'s end" (2010, 569). In his view, the surgeon *can* remove all of the patient's vital organs without intending his death *if* she retrieves the organs from his body without believing that his

death contributes to saving the five (Ibid., 570). How could this work? Consider how Finnis, Grisez, and Boyle justify the performance of a craniotomy:

> …a surgeon who performed a craniotomy and could soundly analyze the action, resisting the undue influence of physical and causal factors that would dominate the perception of observers, could rightly say 'No way do I intend to kill the baby' and 'It is no part of my purpose to kill the baby (2001, 24).

If this works for the craniotomy case, then it should work for the transplant case too ('No way do I intend to kill the patient. It is no part of my purpose to kill him'). But if this is correct, then this shows that Tännsjö's argument depends on the purely first-person account of intention being true, which means one has to be committed to more than just Double Effect and the sanctity of life — one also has to take up this controversial account of intention to make his argument succeed. But this not a view assumed here, and despite the respect I have for its proponents, I think we have good reason to reject it and prefer an account that accommodates some constraints from a third-person perspective on an agent's intentions.[80]

Let us ask this question: can we *soundly* analyze an action while resisting the influence of causal factors concerning death? Obviously, Finnis, Grisez, and Boyle

[80] In fairness to Finnis and friends it does not follow that Tännsjö has a way of preserving Double Effect's proportionality criterion, because one can reject his consequentialist interpretation of it (Tännsjö 2015, 29). This is precisely what Finnis, Grisez, and Boyle do. In an earlier work, they reject the assumption that determining proportionality depends on being able to objectively commensurate the relevant goods at stake; they contend that a condition of fairness has to be met, and that no natural number of individual lives at stake overrides this condition (Finnis, Boyle, and Grisez 1987, 263–68). Because Double Effect is ambiguous with respect to what its proportionality criterion requires, Tännsjö cannot assume that it involves a utilitarian calculus by which the goods at stake are measurable by some objective non-moral standard. To do so is to beg the question. Still, he might complain that the standards of fairness invoked are Kantian in their character (e.g. the Golden Rule or the principle of universalizability) and that we cannot appeal to these by his hypothesis, so let us set this concern aside for the sake of a deeper analysis of where Tännsjö's argument goes wrong.

believe we can, yet their belief depends on the relevant causal factors being "undue" as they say (Ibid.). What makes them "undue" and what exactly does this mean? It is not exactly clear, but a plausible interpretation is that *undue* causes are rationally unwarranted insofar as they are irrelevant for bringing about the end of one's action despite their immediate effects and "impressive physical directness" (Ibid.). It is just not the case that the death of the patient *causes* the five to survive — it is the transplant of the organs removed from the patient into the five, not the death of the patient, that produces this outcome (*pace* Sartorio 2009, 585). But all that follows from this is that death is not intended as the *effective* means to the end; it does not follow that death is not intended insofar as it is *constitutive* of the means chosen to bring about the end. To remove the patient's vital organs and not replace them or supplement their function is to *fatally* injure to the patient, and the life-saving transplant cannot go forward without choosing to inflict this fatal injury. The same is true in the craniotomy case: to empty the contents of someone's head and crush their skull is to fatally injure them (Jensen 2014, 279–80). Physical descriptions like this matter. If they do not, then practical reason is entirely mental, inwardly available only to the agent, something that is completely at odds with commonsense medical practice.[81] In fact, medical textbooks from the nineteenth century represent a conceptual connection between the size-reshaping of the fetus and the destruction of its life. Speaking of the craniotomy procedure, Richard Cooper Norris states that "These terms are applied to all *destructive operations* by which the volume of

[81] Philosophically speaking, the problem is that practical reasoning becomes subject to a 'private language' in which the meaning of its referring terms can only be known to the speaker, something that is impossible as Wittgenstein famously argued. I owe this point to John O'Callaghan who relayed it to me in a personal conversation.

the fetus is reduced in order to permit delivery *per vias naturales*" (Norris 1895, 926 emphasis added on "destructive"). Though the injury may not be choiceworthy for the doctor in itself, it nonetheless remains an injury that must be inflicted, and a fatal one at that. Fatality is built into what is done in these cases, because the nature of human beings is such that they cannot suffer a major change in the shape of their skulls or the loss of the functioning of all their vital organs and survive. Since these forms of surgery are ordered unto death, they cannot be knowingly chosen without intending death even if death is not what precisely brings about the realization of one's goals. Such acts are aimed at death by their nature, and if they are performed on an innocent person, they cannot be aimed only at the good effect (S. L. Brock 1998, 204-05 n17). Thus, Double Effect's requirement that the act be aimed only at the good effect is unsatisfied.

Defenders of the first-person view might reply that there is no good reason why the surgeon must believe that death is included or entailed by the intended state of affairs or the morally relevant description of the action: "cranium-narrowing for the purposes of removal from the birth-canal" (Finnis, Grisez, and Boyle 2001, 26 n38) or "removing the vital organs from the patient's body and transplanting them into the bodies of the recipients." These states of affairs are merely causally related, not conceptually related, to states of affairs involving death. This they maintain in the face of the influential criticism of Philippa Foot, who compared the craniotomy case to a group of cave explorers who use dynamite to blast a fat man stuck in the cave's only exit out of the way so as to avoid the threat of rising flood waters (Foot 1967). As Joseph Boyle says, "In both cases there are two states of affairs — the skull's being collapsed and the fetus's dying, the fat man's being blown up and his dying — which are causally and not intrinsically related." (Boyle

1977, 308). The mere logically possibility that the child or the fat man could survive these ordeals (assume a miracle occurs) creates the logical space for thinking that the bad effect can remain outside the surgeon's intention.

My response to this is to say that the conceptual relation between the relevant procedures and death need not be so strong as to require that it be logically impossible to perform these procedures without death occurring. We should press Boyle to accept a conceptual relation between death *and* the relevant procedures *and*, as he acknowledges, "the relevant physical laws *and* the present state of medical technology" (Ibid., emphasis original). One cannot deliberate between proposals for actions without taking these things into account, since our deliberation is shaped by the causal structures of the world, which are perceived by the one deliberating (Jensen 2010, 463). What we perceive in these surgical procedures is that death is practically inseparable from their operation (we cannot plan on miracles happening). Just as crushing one's skull is a form of killing someone, so too is removing all of their vital organs for transplant. The destruction of human life is not accidently related to these procedures, which gives us a reason for thinking there is a conceptual relation between the two.

A recent analysis of the intend-foresee distinction and the so-called problem of "closeness" by William FitzPatrick helps articulate what I take this conceptual relation to be in terms of *constitution*. He writes,

> [I]f the relation between two states of affairs is known to the agent, natural, and constitutive rather than merely causal, then we cannot properly speak of an agent's intending the one while merely foreseeing but not intending the other (2006, 603).

Some caveats:[82] (1) the relation between two states of affairs need not be known, but only believed insofar as one's intention is concerned, and (2) the relation between states of affairs need not be "natural" because some social practices are sufficient for one state of affairs (e.g. I ordered a pizza and you delivered it) to constitute another (e.g. I owe you for the pizza) (Anscombe 1958[83]). Nevertheless, it follows, as FitzPatrick says with reference to the craniotomy case, that "the fetus's skull's being crushed constitutes its being seriously injured or killed, rather than just being a cause of it, so that it is impossible to aim at the first without thereby aiming at the second (except in the unlikely case of ignorance of the relation between skull crushing and injury or death, which we may set aside)" (Ibid., 595). This explains why the surgeon cannot avoid illicit activity by describing the proposal for action as "cranium-narrowing for the purposes of removal from the birth-canal" or "removing the vital organs from the donor's body for the purposes of transplanting them into the five" without including in the meaning of the description that one is "performing lethal surgery on an innocent person." The mind of a competent surgeon cannot *soundly* exclude death from these sort of proposals for action any more than the mind of a shrewd older brother cannot *soundly* exclude the destruction

[82] (so as to avoid the criticisms of Nelkin and Rickless 2015, 389–93).

[83] I take Anscombe's discussion of "brute facts" to be facts to representative of material causation while O'Brien and Koons take it to be "something analogous to the relation of matter to form" (O'Brien and Koons 2012, 670). How to precisely characterize this relation is not important for my main purpose, which is to claim that "a context of normal procedure" (Anscombe 1958, 71) or a social convention can determine the constitution relations between one state of affairs and another.

of his kid sister's balloon from a proposal to prick it with a pin (Austriaco 2005, 86).[84]

This is not to say that the surgeon's perspective counts for nothing in our moral assessment. If he is mentally unstable, we would judge him differently than we would if he were a Nietzschean sociopath who wants to demonstrate his surgical prowess to himself. Nonetheless, while we may choose an action under a description that best promotes our goals, we should not believe that other descriptions of the very same action are excluded from our intention just because we did not choose them under those particular descriptions. It is one thing to say we do not intend to kill the patient for his organs if we genuinely do not know that surgically removing them for transplant would secure the patient's death (an unlikely possibility). It is quite another to say we do not intend the patient's death if we know better, but choose to act on the basis of a description that fails to represent our knowledge of other un-choiceworthy descriptions that identify the same act.

In our analysis of intention, we should not become beholden to the definite article (*the* intention), as if there could only be one unique intensional description of the action in question (Chappell 2013, 99–101). We should heed the advice of Elizabeth Anscombe who cautions us against "choosing a description under which the action is intentional, and giving the action under that description *the* intentional act" (2005, 223 emphasis orginal). Her words are worth quoting at length:

[84] To be sure, sorting out constitution cases will be tricky. But we should not be too critical of this conceptual relation, otherwise we are burdened with explaining the relationship between crushing the skull and resizing the skull. Surely, the former constitutes the latter!

> The suggestion is that that is *all* I am doing as a means to my end. This is as if one could say: 'I am merely moving a knife through such-and-such a region of space', regardless of the fact that that space is manifestly occupied by a human neck, or by a rope supporting a climber. 'Nonsense,' we want to say, 'doing that is doing this, and so closely that you can't pretend only the first gives you a description under which the act is intentional'. For an act does not merely have many descriptions, under some of which it is indeed not intentional: it has several under which it is intentional. So you cannot choose just one of these, and claim to have excluded others by that. Nor can you simply bring it about that you intend *this* and not *that* by an inner act of 'directing your intention'. Circumstances, and the immediate facts about the means you are choosing to your ends, dictate what descriptions of your intention you must admit (Ibid., emphasis original).

To make his argument go through, then, Tännsjö would have to give some argument for why we should ignore this advice.

Thus, there is no good reason to believe that a surgeon who cuts up a living patient for his organs does not intend to kill the patient for his organs. Anyone who does this causes the patient's death in a non-accidental way since the operation is inherently lethal. For these reasons, then, no one should appeal to Double Effect so as to deny that one kills the patient for his organs by engaging in an act of mortal harvesting.

3.3 Transplant surgery is an activity of shared cooperation

So far, we have been engaging in the familiar thought-experiment of a lone surgeon taking organs from an unsuspecting patient to analyze more abstract principles. Yet such a scenario is not all that feasible. To further defend the claim that someone is killed for their organs if one undergoes mortal harvesting, it is worth reflecting more generally on the sort of activity transplant surgery *actually* is. This sort of surgery typically does not involve a single agent. While it definitely involves a lead surgeon who shoulders the responsibility for the outcome, it is a shared activity that coordinates the actions of a number of individuals, each of whom follows a specific role for the sake of

retrieving at least one organ for transplant, or transplanting at least one organ into a recipient (or both).

Transplant surgery is philosophically interesting because it is an example of a *shared cooperative activity*. As such, the participants exemplify the three characteristics Michael Bratman names in his influential paper on the topic (1992): (1) mutual responsiveness to one another, (2) a commitment to a joint activity, and (3) a commitment to mutually supporting each other in the ways appropriate for carrying out the end of that activity (see also his 2014). Thus, at the very least, a planning theory of intention is involved in their activity, which serves to unify the intentional actions of the individual agents.[85] As Bratman explains:

> According to the planning theory of our individual agency, our practical thought and action is structured by plans, plans that are normally partial and need to be filled in as time goes by. We characterize these plan structures by joint appeal to their characteristic roles in our temporally extended agency and to underlying rationality norms of consistency, agglomerativity, means-end coherence, and stability. Intentions are plan states (Bratman 2015, 1–2).

The element of planning is found in the protocols, which are designed with the intention to facilitate cooperation among the members so as to achieve the best outcomes. In current practice, the management of deceased donors requires serious attention to utilizing and directing the body's remaining functions toward maintaining organ health so that the target organs will remain viable for transplant.[86] One study found a 10% increase in lungs recovered when standard donor management practices involving aggressive therapies were carefully followed (Levine et al. 2003). Refinement of surgical techniques

[85] While I am in agreement with Anscombe concerning the nature of intention in general, it should be noted that Bratman is not, which I nevertheless take to be salutary for my case: one need not be committed to Anscombe's theory to properly understand what sort of activity transplant surgery is.

[86] For a nice overview of this process see McCartney and Wood (2011).

have also yielded net increases of organs available for transplant (Gridelli and Remuzzi 2000). One particularly efficient example is the procedure of splitting a liver from an adult donor into two and transplanting the grafts into an adult and a child (Malatack et al. 1987). Thus, the better the plans and the cooperation there is among the members of the transplant team, the better the chance there is at procuring healthy organs. In a well-working transplant team, all the members of the team act with the intention to achieve the goal of organ recovery when a specific protocol is followed — a protocol being a procedural set of instructions that is able to guide members of the team in their effort to retrieve healthy organs for transplant.

Therefore, if a protocol calls for actions that would have a team secure the donor's death, then any team who successfully follows it intentionally kills the donor. More specifically, to successfully carry out a procedure that secures the donor's death for the sake of retrieving healthy organs is to kill someone for their organs. By way of shorthand, this is what I mean when I say *transplant protocols that would have us secure the death of the donor would have us kill someone for their organs* which is identical with the first premise of my master argument. Insofar as the Don't Kill rule is concerned, these sorts of protocols ought not be followed. To do so would be to engage in mortal harvesting.

3.4 Conclusion

My general strategy in this chapter has been to show how different theories of intention, which emphasize or exclude either the first- or third-person perspectives of the agents involved, lead to counterintuitive claims or faulty conclusions concerning what constitutes medical killing. We saw how defenders of the first-person view could

advocate some counter-intuitive act-descriptions by virtue of their mistaken insistence that only the inward mental content of the description of the proposal for action specifies the action. On the other hand, we saw how Miller, Truog, and Brock disregard the relevance of the first-person perspective as it relates to withdrawing life-support by reducing intentional action to causal relations between different events of physical activity or inactivity. A bare third-personal focus on efficient causation while ignoring the older and more subtle ideas of formal and final causation inherent in intentional action makes it impossible to understand the traditional distinction between killing and letting die, if not human action altogether (Bishop 2006). We should remember that human action in a medical context is voluntarily directed by reason to some end or goal, and whether it is in the form of the end or the means to the end, it can have its own end-directed nature evident to observers situated in a context of established social practices. This fits well with the planning theory of intention we find inherent in transplant protocols, and it helps us avoid the mistake Coons and Levin make when they separate the act of killing *by* surgical organ removal from the act of killing *for* organs, as if the former has no end-directed relation to the latter, particularly in the context of organ donation. What we should learn from all of this is that an adequate view of intention is indispensable for making sense of the subjects of ethical analysis, that is, human actions; having an impoverished view or no view at all leads us astray.

Therefore, as far as intentional actions are concerned, transplant protocols that would have is secure the donor's death would have us kill someone for their organs.

Chapter 4: What Makes Killing for Organs Wrong?

Abstract: Chapter 4 defends the second premise of my master argument, that killing someone for their organs is disrespectful to the worth of the one killed. The fundamental problem with such a practice, to which I assume the donor consents, is that it bestows more worth on the organs than the donor who has them. What is at stake is the very basis of human equality, which is an ineliminable dignity that each of us has in virtue of having a rational nature. To allow mortal harvesting would be to make our worth contingent upon variable quality of life of judgments that can only be based on properties that come in degrees. Thus, rejecting the ban on killing donors comes at the expense of our egalitarian principles.

"True guilt arises only from an offense against a person, and a Down's is not a person. There is no cause for remorse, even though, certainly, there is for regret. Guilt over a decision to end an idiocy would be a false guilt, and probably unconsciously a form of psychic masochism. There is far more reason for real guilt in keeping alive a Down's or other kind of idiot, out of a false idea of obligation or duty, while at the same time feeling no obligation at all to save that money and emotion for a living, learning child."

— Joseph Fletcher

"As far as the right to life is concerned, every innocent human being is absolutely equal to all others. This equality is the basis of all authentic social relationships which, to be truly such, can only be founded on truth and justice, recognizing and protecting every man and woman as a person and not as an object to be used."

— John Paul II

4.0 Introduction

In this chapter, I defend the second premise of my master argument, that killing someone for their organs is disrespectful to the worth of the one killed. As will be made clear, the fundamental problem with such a practice, to which I assume the donor consents, is that it bestows more worth on the organs than the one who has them. What is at stake is the very basis of human equality, which is an ineliminable dignity that each of us has in virtue of having a rational nature. To allow mortal harvesting would be to make our worth contingent

upon variable quality of life of judgments that can only be based on properties that come in degrees. Or so I shall argue in the coming pages.

In the first section I defend the notion that the wrongness of killing involves an act of disrespect, though I deny that it is our autonomous choice that is the primary object of respect; rather, I contend that it is the human person as an individual substance with a rational nature. As I've already mentioned, such beings possess an ineliminable dignity that implies that there is no threshold one can cross in the diminishment of one's well-being that would make us worthy of destruction. Some preliminary words about this are in order as "dignity" is sometimes thought to be a "useless" concept (Macklin 2003). I do not mean to dispute that there is some sense in which we lose our "dignity" in suffering, insofar as "dignity" is understood as a subjective sense of self-worth or self-respect. But the kind of dignity I am talking about is more fundamental, an objective kind that makes us *matter*, and therefore, makes our suffering matter. Why should we believe in this? Here is my quick and dirty argument. If this dignity could be stripped from us through suffering or other deprivations (suppose we are forever deprived of the ability to feel pain), then our suffering would matter less and less, the more and more our dignity diminishes through suffering or deprivation. But this is not the case. Therefore, we have a dignity that cannot be stripped from us.[87] This is the most I will say about this, so whatever disagreement one might have at this point will either have to grant me my assumptions for the sake of argument or dismiss the argument entirely.

[87] The astute reader will note that this argument constitutes my reasons for rejecting sentience as the criterion for moral *status*, though I affirm that it does make one morally *considerable*. As I understand the terms, moral status does not come in degrees whereas moral considerability does.

In the second section I argue that the basis for our dignity is our rational nature, which is marked by the possession of a basic, natural capacity for rational action. This account is grounded in a capabilities-style approach that conceives of human beings as members of a natural kind that has at its root the capacities for rational action, the kind of action that is constitutive of human flourishing, something that everyone agrees ought to be safeguarded if not promoted. Kind membership is what matters for having these capacities, not a certain degree of their performance. Essentially, the argument I defend is that if anything has the set of basic capacities for rational action, it has dignity (or "moral status"); all human beings have that set no matter their level of maturity or disability; therefore, all human beings have dignity, which makes them objects of respect (following DiSilvestro 2010). I then address objections to this argument, specifically from the appeal to "marginal cases" (anencephalic infants, PVS patients, etc.) which is supposed to show that killing such individuals is of no more concern than killing a non-human animal.

In the third section I address the objection that the true nature of respect involves honoring the wishes of the donor, and not the donor's life. In the final two sections I show how our political equality is threatened by a policy that would permit mortal harvesting. Traditionally, an unacceptable reason for killing is to kill an innocent human being in order to benefit another, which is an application of the longstanding Talmudic principle *ain dochin nefesh mipnei nefesh* — one life may not be set aside to ensure another life (Choong 2014; Jotkowitz 2008). This principle is precisely what is at issue in the debate over the rule against killing donors for their organs, whether it be authorized by the donor or not. Those who reject the dead-donor rule must reject this principle. But doing so comes at a cost: either our egalitarian principles ought to be revised or none of

us are protected from being exploited for whatever purpose is deemed expedient. What follows, then, is my account of this position.

4.1 The wrongness of killing: A matter of respect

Respect-based theories feature prominently in the ethics of killing. They are typically contrasted with harm- or deprivation-accounts, which make the badness of the victim's death central to the wrongness of killing, something respect-based theories deny. The classic representation of the deprivation account is articulated well by Don Marquis; he says "for any killing where the victim did have a valuable future like ours, having that future by itself is sufficient to create the strong presumption that the killing is seriously wrong (1989, 195 emphasis original). More succinctly, Ellen Kappy Suckiel says, "*if dying is not always bad, then killing may not always be wrong* (1978, 47 emphasis original). This claim seems intuitive to many, and a vivid illustration of the power of this "intuition" comes from the honest words of Jonathan Glover:

> It does not seem plausible to say that there is no *conceivable* amount of future misery that would justify killing someone against his will. If I had been a Jew in Nazi Germany, I would have considered very seriously killing myself and my family, if there was no other escape from the death camps. And, if someone in that position felt that his family did not understand what the future would feel like and so killed them against their wishes, I at least am not sure this decision would be wrong (1977, 82 emphasis original).

Anyone familiar with the Holocaust literature will understand, however dimly, the bleakness of such a future. It is not hard to see the reason behind the malediction of an inmate who 'greeted' Elie Weisel and his father with these words, "You should have hanged yourselves rather than come here. Didn't you know what was in store for you here in Auschwitz?" (Wiesel 1958, 30). Sadly, examples like these could be multiplied, so let us suppose for the sake of argument that the deprivation account is correct. Then

how do we explain the wrongness of a Nazi SS officer's action when he shoots a hysterical mother dead on her way to the gas chamber? After all, he eliminates the cause of her hysteria: the thought of watching her two small children die from poison gas twenty minutes later. We might think his action is wrong insofar as it causes bad effects on her kids and those around her, or insofar as it comes from a vicious character (or both). Be that as it may, neither of these explanations address what he does *to her*, and since the deprivation account is only concerned with what he takes away from her, which certainly is not a "future of value," he does nothing bad to her and perhaps something nice. This is hard to believe. What remains unexplained is the fact that he *wrongs her*, and that he does not merely *act wrongly* with respect to some principle of utility or theory of human flourishing. Furthermore, there is a sense in which the Nazis wronged their victims *equally*. Suppose the woman's children die in the gas chamber with their elderly grandfather; it seems that the killing of the grandfather is just as objectionable as the killing of the grandchildren even though a greater deprivation of life-goods is suffered by the children. While our sense of tragedy may vary with the amount of life-goods lost, our sense of injustice does not. Why is this? An intuitive, though I think not fully satisfying, answer is that the Nazis took their victim's lives without their consent. As Warren Quinn explains,

> Among the several moral reasons you may have not to kill me, take me captive, or subject me to your idea of the good life, perhaps the most important lies in the simple fact that I *choose*, or would choose were I to consider the matter, that you do not. Viewed in this way these rights are *nothing other* than equally distributed moral powers to forbid and require behavior of others, and violations of them are *nothing other* than refusals to respect the exercise of these powers (1984, 49 emphasis original on 'choose'; emphasis added on 'nothing other').

Since the choice to go on living is all-or-nothing, the violation of that choice is all-or-nothing. Hence, a principle of respect for autonomy remains unsatisfied, and this seems sufficient to explain how it is that the Nazi's not only wronged their victims, but wronged them *equally*.

4.1.1 Against the disjunctive theory

Respect for autonomy, however, is not absolute; nearly everyone is agreed that it would be impermissible to kill healthy people upon their request.[88] Fortunately, respect-theorists need not and should not deny that part of what explains the wrongness of killing is that it harms the victim in terms of a deprivation of life-goods lost in death. Nor are those who contend for deprivation-accounts required to deny the moral significance of respect. Hence, the prominence of what I shall call *disjunctive* theories, which incorporate the moral significance of respect, and identify autonomous choice as the relevant object of respect. Though they vary in their details, what unifies them is the general claim that the wrongness of killing can be explained either in terms of the harm done to the victim, or the disrespect to the victim's autonomy, or both (e.g. Quinn 1984; McMahan 2002, chap. 3; Luper 2009, chap. 7). On this view, it is permissible to kill an innocent person, S, if and only if (1) S is not (or is only minimally) harmed by death, and (2) S gives valid consent to be killed by some humane means; it is wrong to kill S just if one of these conditions is unsatisfied. That killing someone who meets these conditions might benefit others, as it would in organ donation, only bolsters the reason for killing by

[88] A notable exception is John Harris who writes, "'Should I be permitted voluntarily to donate a vital organ like the heart? Again, if I know what I am doing then I do not see why I should not give my life to save that of another if that is what I want to do" (Harris 1992, 113). Yet his respect for autonomy is merely pragmatic, since as he (in)famously argued that it would permissible to institute a "survival lottery" in which some people were killed at random for their organs regardless of their consent (Harris 1975).

transplant surgery; hence, the disjunctive theory is attractive to those who would sanction such actions and something like it is asserted by everyone in favor of mortal harvesting.[89]

Plausible as it may be, the disjunctive theory is unsatisfying. What exactly counts as a "harm" and who decides whether or not it is "negligible?" If harms are just setbacks to one's interests (Miller and Truog 2012a, 115; Feinberg 1984), and one has an interest in sacrificing one's life for others above all else, why must the donor even be sick? A healthy person, perhaps like the main character in the film *Seven Pounds* (Columbia Pictures, 2008), could claim to be harmed if this preference goes unsatisfied, which just collapses harm into the logic of preference satisfaction making the disjunctive theory redundant.[90] To be sure, the relevant sense of harm is often construed as something lost in terms of a "worthwhile life" (Glover, 1977), or "biographical life" (Rachels, 1986), or "a future of value" (Marquis, 1989) or an exercisable ability "to act or do things" (Sinnott-Armstrong and Miller, 2013). It seems that there is little if not nothing left to lose near the end of life if these things constitute what is lost in an act of harmful killing. But who

[89] There is a discussion worth commenting on about the so-called "Nothing is Lost" principle (NIL), which purportedly permits the killing of the innocent when (1) the innocent will die regardless of what is done, and (2) other innocent life will be saved. Somewhat recently, it was put forward by Gene Outka to justify lethal experimentation on spare embryos left-over from *in vitro* fertilization practices. Interestingly, Outka realizes that NIL justifies mortal harvesting and even medical experimentation on those "who are slated for death anyway" (2002, 205). To avoid these results, Outka appeals to one's "agential history" to make it "*impermissible* to destroy *any* entity for body parts even if "he or she does not now have any considerable future" (Ibid. emphasis original). Miller and Truog are eager to endorse NIL, but reject Outka's "agential history" criterion as irrelevant (2012, 136–40; more on the irrelevance of an "agential history" below). Yet their endorsement of NIL is qualified in terms of two additional conditions: (1) the donor must not be harmed, and (2) the donor must provide valid consent. Given these conditions, the NIL principle does little to *justify* mortal harvesting, and only names conditions that motivate it; avoiding harm and respecting autonomy do all the work. This is why we should focus on disjunctive theories of the wrongness of killing, and leave this principle aside.

[90] That healthy people are willing to give up their lives for the sake of organ donation is not a fanciful one. It was reported that Stanford's heart transplant team was contacted by healthy individuals who wanted to sacrifice their lives for the sake of saving others and advancing medical knowledge (Elliott 1995, 95). On the idea that one can be harmed if one is disrespected, see Koppelman (2003).

decides whether there is little if not nothing left to lose? If it is the patient, then we are back to the logic of preference satisfaction again, which makes the disjunctive theory redundant. If it is the doctor or some legal authority, then this assumes that people other than the patient are in a position to determine whether the harm of death would be acceptable or not if the patient's death wish were honored. We would privilege the patient's wishes only when others (with some authorized standing) have judged her life not to be worth living. Consequently, the patient's self-determination ends up being quite limited because she is only empowered to give up her life when she is in a diminished state (Menikoff 2003); an autonomous choice for death deserves no respect if she is healthy. Moreover, if the patient is terminally ill but chooses to go on living, her choice will require some sort of justification if she is to be judged rational. Since we expect human beings to provide reasons for their choices, the patient is required to justify her continued existence under the pain of irrationality in a way that healthy people are not (Velleman, 1992). This inequality is entirely contingent upon one's health status, and therefore places an unfair burden on the vulnerable so that they might enjoy one of the most basic rights that should be guaranteed by any just society: the right not be killed. The sort of "autonomy" given to the dying in the disjunctive theory masks a form of paternalism more insidious than the kind the bioethics movement rejected in the 1970s, and therefore the disjunctive theory should be rejected if autonomy is to have the sort of worthiness of respect it is assumed to have.

On the other hand, it is not unreasonable to think that autonomy is being respected too much. It may be against your will for me to poke you in the belly, but violating your autonomy in this respect is not nearly as serious as me killing you against your will. What

your will is concerned with matters quite a lot more than just the mere fact that you have a will concerned with something, which indicates that the respect-worthiness of your autonomy is determined by goods that are more fundamental than the good of autonomy itself (Oderberg 2000, 58–59; *pace* Quinn's "nothing other" clause above). Another way autonomy may be respected too much is found in arguments that conclude that incompetent individuals are just as entitled to the so-called "benefits of death" as competent individuals from considerations of suffering (Doyal 2006). Since the suffering of the incompetent matters no less than that of the competent, it is unfair for the competent to be entitled to the so-called "good of death" and not the incompetent (Rachels 1986, 179–80). It has long been observed that the disjunctive theory is simply an *ad hoc* proposal that compromises between autonomy-based and harm-based justifications for killing for the sake of garnering legal support for euthanasia.[91] With respect to euthanasia and the twin requirements of the disjunctive theory, Daniel Callahan explains that:

> Each [of the requirements] has its own logic, and each could be used to justify euthanasia. But, in the nature of the case, that logic, it seems evident, offers little resistance to denying any competent person the right to be killed, sick or not; and little resistance to killing the incompetent, as long as there is good reason to believe they are suffering. There is no principled reason to reject such logic, and no reason to think it could long remain suppressed by the expedient of an arbitrary legal stipulation that both features, suffering and competence, be present (Callahan 1993, 108–9).[92]

Even if the legal stipulations were to remain intact with respect to mortal harvesting practices, there would be no reason why the disjunctive theory should not be deployed to

[91] Rachels thinks that legislation limiting euthanasia to the voluntary variety is "devious" (Ibid.).

[92] While competence may be "present" through an advanced directive, it still begs the question as to why they would be needed at all if the good of death can bring about an end to suffering and a set of healthy organs to others who need them.

justify killing for the sake of medical experimentation, something few are willing to entertain (a case of under-respect for autonomy?). As long as its conditions are satisfied, it really does not matter how we use the living body before us. None of this counts as decisive refutation of the disjunctive theory, but it does motivate a search for better one and at least raises a more fundamental question: what is it that ought to be respected in a respect-based view of killing?

4.1.2 The human person as the primary object of respect

I submit that the individual human person ought to be primary object of respect. By "human person" I mean a flesh and blood Aristotelian substance that is a rational animal, not something that just so happens to fall under an abstract description of being an "autonomous agent" whatever that might be. Classically understood, the human person is an individual substance with a rational nature (as Boethius would put it), a definition that is hard to improve upon (Simpson 1988). This enduring idea includes both autonomous and non-autonomous individuals, something that is recognizable in the Belmont Report's statements on "Respect for Persons." As it says, "persons with diminished autonomy are entitled to protection" and may be so severely compromised that they should be excluded from activities that may harm them (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979, 4).

One must distinguish this view from the contemporary one that reduces respect for personhood to respect for autonomous agency, and consequently leaves those with diminished autonomy at risk of not being protected (e.g. newborn infants in Tooley 2009; Giubilini and Minerva 2013). As M. Therese Lysaught (2004) has shown, one can find this subtle, but substantive shift from the particular human being to the property of

autonomy in the early editions of the Beauchamp and Childress' *Principles of Biomedical Ethics* as well government reports on research involving human embryos (e.g. Advisory Committee 1994).[93] In the first edition of their famous book, Beauchamp and Childress interpret Immanuel Kant as saying "a moral relation between persons is *always* one where there is mutual respect for autonomy" and then infer that, "The principle of autonomy thus applies to persons with autonomous choice" (Beauchamp and Childress 1979, 59–60 emphasis added).[94] What might protect those with diminished autonomy is what they call "the principle of human worth" according to which "human life has an intrinsic value irrecoverably destroyed" in an act of killing (Ibid, 87, 88). While this resembles what I am defending it is much too abstract and impersonal, which perhaps explains why they thought the most reasonable interpretation of it is that "killing is prima facie wrong and so permissible only if it is necessary to save the life of at least one innocent person…" (Ibid., 88) — something that is quite compatible with mortal harvesting![95] Contrast this watered down "principle" with the statements from Paul Ramsey's influential work (which appeared before the baleful era of "principlism") that banned mortal harvesting "out of respect" for the human being that is "presented to us with its moral claims solely within the ambience of a bodily existence" (Ramsey 1970, 190–91). Further contrast Ramsey's notion of respect as "holy awe" (Ramsey 1968, 76)

[93] In the latest edition of their book, Beauchamp and Childress reply that Lysaught has misunderstood them to be implying that they deny that non-autonomous human beings are not worthy of respect (Beauchamp and Childress 2013, 108, 142n12). Perhaps that is the case, but the question remains as to what exactly it is that makes diminished human persons worthy of respect in the first place.

[94] In the second edition they remark that the principle of autonomy "does not apply to persons who are not in a position to act in a sufficiently autonomous manner" (Beauchamp and Childress 1983, 64).

[95] The remaining part of the sentence concealed by the ellipses is "…or if it is necessary to preserve a morally worthy society."

with the contemporary rhetoric of "respect" that has become so separated from the norms of protection and so abstracted from the bodily subject before us, that we are now called to give "profound respect" to human embryos while at the same time being told it is quite permissible to destroy them for research purposes (Ethics Advisory Board 1979, 101; e.g. Fitzpatrick 2003, 31). Such "respect" is not the kind anyone should want.

A recovery of a respect for persons in their bodily life, where they are prioritized above whatever contingent properties they might have, is not only necessary for safeguarding the individual from abuse and honoring the dignity inherent in each of us (the dignity that makes our suffering matter), but it is also sufficient to explain what is fundamentally wrong with killing: it simply *destroys* someone.[96] Theories of the wrongness killing that focus exclusively on the loss of the properties of the person, whether it be a future of value or an autonomous will, are pathologically forgetful of the particular being killed and leave aside this obvious factor in what makes killing wrong when it is wrong. As Timothy Chappell[97] remarks, "deprivation is not the main thing wrong in killing, even when it is part of what is wrong. In killing, the main point is not that something is taken away from someone, but that the someone is taken away" (Chappell 2004, 111). The issue, then, is what *grounds* our dignity, that is, our worthiness of respect such that we should *always* be protected from being destroyed for utilitarian benefit.

4.2 The ultimate capacity for rational action as the basis of human dignity

I submit that the ultimate capacity for rational action is the basis of human

[96] Or for those pesky substance dualists, it simply destroys someone *on this earth*.
[97] Who now goes by the name Sophie Grace.

dignity. What I mean by these terms will become clearer in the argument that follows. We can begin by assuming that anyone who can read this text has human dignity, which I will identify with "moral status" going forward. That is to say, they should be respected as individuals who bear certain fundamental rights guaranteeing them the opportunity to pursue human flourishing. Since they are able to be self-aware, make their own choices, use language, engage in humor, be creative, form friendships, and pursue knowledge, economic efficiency, political organization, and perhaps God or a sense of the ultimate, we accord them a special status. And since human flourishing involves all of these activities in one form or another, it is not uncommon to find lists of this sort in the literature that relate these distinctively human capacities to our ethics of killing (even unto radically different conclusions; e.g. Nussbaum 2008; Finnis 2011). I shall follow in this line of thought, because the virtues of doing so is that we (1) generate criteria for moral status that are not arbitrarily speciesist, which (2) can help explain why killing a human being is a more serious matter than killing a non-human animal; these I take to be desiderata for a good theory of the wrongness of killing.[98] I use "rational action" as a kind of general term for all of these activities. To be sure, there is a sense in which some non-human animals engage in "rational action" insofar as they engage in means-to-ends reasoning and pre-linguistic communication (MacIntyre 1999). Yet what remains distinctive of human animals is that they are able to give and evaluate reasons for their

[98] A further comment on sentience: sentience is unable to help us explain why it is a more serious matter to kill a human being than a non-human animal. Since both can experience pain, there is no reason to suppose that our capacity to suffer pain matters more. That human beings may have a greater capacity for suffering than non-human animals is due to our capacities for rational action: we are able to understand what it is happening to us and others in ways animals do not, and part of what we understand is the loss of life-goods towards which we are directed.

actions, something I take to be distinctive of "rational action" as I deploy the term. That is, if one is able to perform a rational action, then one is able to give and evaluate a reason for doing so. We might want to amend our lists of actions in various ways, but the general idea is that each of the forms of activity mentioned signifies rational action — that is what matters in each of them. Hence, the wide and enduring agreement that the sort of activity relevant for moral status or our "dignity" is related to rational action (from the Stoics to moderns, especially Kant).

4.2.1 Why ultimate capacities must matter morally

Of course, it isn't just rational action *simpliciter* that matters, it is also our capacity to perform it. Indeed, capacities for rational action *must* matter morally.[99] If only actual exercises of rational action mattered, then we would lose our moral status every time we fall into a deep, unconscious sleep, which is absurd. Nor does the likelihood that I will perform some rational action in the future matter. If I am now under anesthesia which would keep me out for a few hours, and it is true that I will die from a falling meteor ten minutes from now, it does not follow that I lose my moral status ten minutes before impact. Nor does the fact that I have a history of rational action matter.[100] If Parfit's replication booth exists (Parfit 1984, 199–200), and it is true that Jones will require a heart transplant at age 50, and he scans himself "in" at age 20, and Jones-clone is scanned "out" when the time comes for the transplant, it does not follow that Jones-clone would have no more moral status than a brain-dead body just so long as he is kept

[99] The following is largely a summary of the argument developed by Russell DiSilvestro (2010, vol. 108, chap. 3)

[100] Recall that Gene Outka is someone who appeals to a person's past accomplishments of rational action to make it "*impermissible* to destroy *any* entity for body parts even if "he or she does not now have any considerable future" (2002, 205 emphasis original).

from waking up. The unavoidable implication is that potentiality for rational action, in some relevant sense, is both necessary and sufficient for moral status.

Although it is not easy to specify the relevant sense of this potentiality (see Lizza 2014), we all recognize the moral status of those who have an immediately exercisable capacity for rational action. To have an immediately exercisable capacity for rational action just is to have a *first-order* capacity to perform some rational action that is not impeded by some circumstance or condition (DiSilvestro 2010, 108:26). Yet while the presence of this capacity is sufficient for us to recognize that one has moral status, it is not necessary to ground it. The dramatic story of Douglas Copland's *Girlfriend in a Coma* (1998) illustrates well how a temporary change in one's possession of a first-order capacity for rational action does not affect one's moral status. As the story goes, Karen McNeil wakes up from a coma she is in for seventeen years. But if only first order-capacities matter, then Karen had no more moral status than a brain-dead body in the time between her conscious states, and she could have been volunteered for transplant surgery at any time in between. The same would be true of Terry Wallis, a man who awoke from a nineteen-year-long coma and recovered fluent speech (Schiff and Fins 2007). Although Wallis was misdiagnosed as being in a vegetative state when he actually was in a minimally conscious state (Giacino et al. 2014), he nonetheless lacked a first-order capacity for rational action while he was in it. Are we to believe that his moral status came and went with his first-order capacities for rational action? We might think so because of the length of time involved, but then how much time? There is no determinate answer. If Wallis had only lost his first-order capacities for nineteen days, we could not plausibly believe his moral status disappeared for nineteen days too.

What if we move up in the order of capacities so that our capacity to have a first-order capacity for rational action is what grounds our dignity (call this a second-order capacity)? Answer: we can run what Russell DiSilvestro calls a "temporary change" argument to show that what is true of the first-order capacity is also true of the second-order capacity (DiSilvestro 2010, 108:37–42). Suppose Wallis loses his second-order capacity for rational action, but retains a third-order capacity for the second-order capacity (i.e., he has the capacity to develop the capacity for having a first-order capacity for rational action). As time progresses, say for nineteen days, he regains his second-order capacity. Again, we cannot plausibly believe his moral status disappeared for nineteen days too. Once we get on the wheel of arranging capacities in a hierarchal fashion, we are off to the races until we terminate in what might be called an "ultimate" or "root" or "radical" or "basic" or "natural" capacity (Moreland and Rae 2000, 200–202), which, I submit is the ground of our moral status. The upshot is that, for any non-ultimate order of capacity for rational action that we stipulate, we can always conceive of a temporary scenario where that order of capacity is lost (e.g. the second) and a higher-order capacity remains (the third), and therefore your moral status remains. Therefore, as long as you have the capacity, at *some level or other*, to perform a rational action at any given time, you have moral status at that time (DiSilvestro 2010, 108:75).[101]

4.2.2 What about "defective" humans or permanent changes?

Let us suppose the foregoing is correct. Still, it may be the case that we can

[101] We should be careful to note that basic capacities are not numerically distinct from first-order capacities; rather, they are the "root" of a single capacity that "flowers" into an immediately exercisable one given enough time and nurture. Conceptually parsing them in terms of first-order, second-order, and basic capacities is just a convenient heuristic for explaining their properties and their significance for moral status (see Lee's interesting reply [2011] to Marquis [2011] on this point).

survive the loss of our ultimate capacities for rational action, and that we persist on as a "human vegetable." Therefore, if our moral status goes with our ultimate capacities for rational action, and if we survive the loss of those capacities, then we will no longer have moral status. There seems to be no reason to believe that the length of our lives and the time we have our moral status are co-extensive. We all know some changes are permanent; some injuries are so devastating that there is no coming back from them. Isn't the forgoing argument limited to temporary changes, in which there is a realistic possibility of recovery? The fact that recovery is logically possible (via miracle) is simply not strong enough for us to judge that someone who is permanently changed possesses the relevant capacities for rational action — they seem to be lost forever. Thus, as interesting as the argument may be for establishing the moral status of the very young or temporally unresponsive, it does nothing for those who are typically thought to be eligible for mortal harvesting: anencephalic children and PVS patients (Marquis 2011, 15).

What to make of these objections? Certainly, it does not follow from my argument's premises that that we cannot survive the loss of our ultimate capacities for rational action. But neither does it follow that we can. That is an issue that stands independent from the argument. The question to be settled, then, is whether our ultimate capacities for rational action are *essential* to us. This brings us back, once again, to the nature of human beings; what reason is there to believe that the basic capacity for rational action is constitutive of human life? Why should we think that anyone who has the capacity to live a biologically human life automatically has a capacity for rational action?

The answer I shall defend is this: we cannot make sense of the human life form without conceiving it as having a rational nature. While this claim is initially startling, there is some evidence for it that can be found even in the writings of those who are skeptical that all human beings have a basic capacity for rational action. Consider the words of Jeff McMahan when he speaks of "a *defective* human embryo that lacks the potential to develop into anything other than an anencephalic infant" (2002, 210 emphasis added). Or the case of Peter Singer who takes the following to be an "obvious" truth:

> If we compare a *defective* infant with a nonhuman animal, a dog or a pig, for example, we will often find the nonhuman to have superior capacities, both actual *and potential*, for rationality, self-consciousness, communication, and anything else that can plausibly be considered morally significant (1994, 201 emphasis added).

McMahan concurs when he says that those who are "severely retarded" are not only cognitively comparable to certain non-human animals, "they also have *no more potential* than those animals" (2002, 205 emphasis added). Now, there is a sense in which these claims are true if they are only talking about *some* level of potential, but it seems that they are making a stronger claim about *some level of potential or other*.[102] What is puzzling about these claims is that if such individuals lack potential for rational action at *every* level, then they are not "defective" or "retarded" in any way. They simply develop as they are *supposed* to develop and actualize exactly what they are in potency; yet McMahan and Singer are eager to classify them in the set of things which have gone

[102] This also appears to be the case with Miller and Truog who, when writing of those just fall short of whole-brain death, say, "these patients lack *any* capacity for experience, owing to profound brain damage and the absence of any responsiveness to stimuli indicative of sensory awareness…" (2012, 121 emphasis added).

awry.[103] What makes their claims so puzzling is that they assume that these so-called "defective" humans are not supposed to be the way they are; rather, they are supposed to develop into, and function as, a mature member of the human species. The old-timey ideas of a human nature perfected by its complete development and the species-grounded norms associated with concepts like health and proper function haunt these claims, despite the fact that both of these thinkers work within a broadly neo-Humean tradition that purports to be skeptical of such things.[104]

The point I want to make is this: basic or ultimate capacities for rational action are present even in cases of severe disability or injury, because we would not be able to make sense of 'disability' or 'injury' if these capacities were not essential to human beings in their nascent or waning forms. A germ of this idea is found in Aristotle when he says:

> If, though either the thing itself or its genus would naturally have an attribute, it has it not; e.g. a blind man and a mole are in different senses 'deprived' of sight; the latter in contrast with its genus, the former in contrast with his own normal nature (*Metaph*. V.22).

[103] This tension is especially evident in McMahan's writings where he seems to assume a 'genocentric' view of organisms, which views organisms and their features as being determined by their genetic code. This explains his difficulty in making sense of a human being without a genetic basis for the development of a rational nature that is still "internally directed toward the full realization of its inherent nature as a rational being" (2008, 90). Indeed, he ought to be puzzled if one's genetic constitution exhausts one's internally directed capacities. But why assume that? An 'organacentric' view of organisms takes more into account, specifically its dynamic epigenetic systems, to explain how it is that an organism's development is internally directed (The genocentric/organacentric distinction belongs to Goodwin 1994, 3). On this view, a condition like anencephaly would arise not from some genetic mutation, but from disruptions in the interaction of epigenetic factors. This controversy over the nature of the organism is not obscure either as it turns up in cancer research (Baker 2014; Prehn 1994): is cancer caused by genetic mutations or developmental problems? My point, however, is not to say what happens in anencephaly; rather, it is to say that *if* it is a result of some genetic mutation, then we should not, as McMahan does, speak of human organisms with anencephaly as undergoing some developmental failure.

[104] Note McMahan's candid admission to Tim Mulgan (2004), when he says Mulgan is "obviously right" when Mulgan says "McMahan wants to combine a naturalistic, broadly Humean, picture of a world where continuous properties come in degrees, with a set of Kantian intuitions that clearly require sharp boundaries between persons and non-persons. This is an essentially unstable combination" (McMahan 2008, 94).

Human injuries and disabilities, then, are understood in light of the "normal nature" of human beings. While "normalizing" the body is anathema to certain social constructivists, especially in the disability rights movement, the idea of a healthy, well-working human life form is hard to escape. Insofar as the disability literature is concerned, this helps explain why it is common among some social constructivists to distinguish between "impairment" and "disability" where the former refers to physical defects of the body, and the latter to a stigma or prejudice imposed on those defects by society (e.g. Oliver and Barnes 2012, 22).[105] The general idea is that there is a picture of health relative to the human form that is defined, not by some statistical model of averages (which, e.g., regarding eyesight measures below 20/20), but by capacities intrinsic to the human form itself (20/20 is the standard for human vision regardless of the average), and thereby constitutes our idea of a well-working member of the species (contra Boorse 1977).[106] As Michael Thompson writes, "every thought of an individual organism as alive is mediated by thought of the life-form it bears. A true judgment of

[105] Elizabeth Barnes has perhaps the best and most consistent approach to the social model of disability I've seen that avoids "normalizing" the body. In her view, someone, S, is physically disabled in a context, C, if and only if:

1. S is in some bodily state x.
2. The rules for making judgements about solidarity employed by the disability rights movement classify x in context C as among the physical conditions that they are seeking to promote justice for. (Barnes 2016, 46).

Yet dropping the idea of a healthy, well-working human life form from her analysis produces curious results. On her model, pregnant women in the work place are physically disabled. Now there is a sense in which this is true, but another in which it is not. Other complications notwithstanding, pregnancy is a sign of *health*. Pregnant woman are "disabled" only if disability makes no reference to health, and only to contingent social factors that make discrimination against pregnant women possible. Obviously, we have prudential reasons to classify pregnant women in the workplace as "disabled" since it so happens that there are legal protections for them at stake if they are so classified. But this is just a contingent social fact that is a result of our imperfect attempt to safeguard the welfare of pregnant women in the workplace, something that any just society could protect without appealing to the concept of disability.

[106] Michael Thompson draws attention to how the truth conditions of what he calls "natural historical judgments" do not depend on statistical inference. As he says, "although 'the mayfly' breeds shortly before dying, *most* mayflies die long before breeding" (2008, 68 emphasis added).

natural defect thus supplies an 'immanent critique' of its subject" (2008, 81).[107] No doubt, all things considered, a blind person can be healthier than a sighted person, but if all other things are equal, a sighted person is healthier than the blind. Yet this *ceteris paribus* comparison does not hold between humans and moles; nor does it hold, for the same reasons, between non-disabled individuals and the sort of individuals Singer and McMahan call "defective" *provided that* they are correct in their claim that such individuals have no potential for rational action at *some level or other*. The consistent thing to say is that such individuals are not even human at all.

One thinker who is refreshingly consistent on this point is Martha Nussbaum. She writes,

> Some types of mental deprivation are so acute that it seems sensible to say that the life there is simply not a human life at all, but a different form of life. *Only sentiment* leads us to call the person in a persistent vegetative condition, or an anencephalic child, human (2006, 187 emphasis added).

She accepts this counter-intuitive claim, because she thinks it is more acceptable than the alternative: that such an individual is human, but will "never be able to have a flourishing life despite our best efforts" (Ibid.). While I will leave it to the reader to decide if she is ultimately correct, I think there is more than just "sentiment" involved in our judgments that such individuals are human.[108] It is one thing for a PVS patient's friends and relatives to think that their loved one now lives a life not worth living or even no longer exists *as* a

[107] More clearly, he says "Your observations, which are at bottom always observations of individual organisms, will thus lead in the end to a possible *critique* or *evaluation* of individual organisms and their parts and operations. And they will lead to the articulation of general standards of critique applying to organisms of the kind in question. This sort of critique of the individual is everywhere mediated by the attribution to it of a specific form; to bring an individual under a life form is, we might say, at the same time to bring it under a certain sort of standard" (Thompson 2004, 55 emphasis original).

[108] The problem with sentiment is that it cuts both ways: it may very well be that what motivates some to literally dehumanize the PVS patient and the anencephalic baby is sentiment, the kind that underlies contempt rather than care for the body before us.

person in some qualified sense; it quite another to think that there loved one is not there at all (Olson 2009, 95). No doubt, one could embrace a tough-minded body-self dualism, which identifies us with something that can only be accidently related to the human organism lying there in the hospital bed, but body-self dualism is both contrary to Nussbaum's assumptions and metaphysically dubious. Nor does it follow from her assumption that being capable of a flourishing life is essential to "human life" that the anencephalic child or the PVS patient lack this capacity at *every* level. It is perfectly reasonable to suppose that someone in a PVS who is protected and cared for has a more flourishing life than one who is starved, mocked, or sexually abused. The same can be said of the anencephalic child; better to be held and made comfortable in the little time that remains than to be thrown in the medical waste bin as if the anencephalic baby were on the same metaphysical plane as its placenta (of human origin, but not a human being). It is simply not the case that nothing good or bad can happen to a person if that person has no way of experiencing what is happening.[109] The capacity to experience one's state of flourishing may be absent, but that capacity is not required to enjoy the opportunity to flourish as such.[110] No doubt such opportunities are limited and will look quite different from those of a healthy adult, but they are nevertheless real opportunities with real human goods at stake.[111]

Aside from these complaints, however, is the more important question Nussbaum

[109] *Pace* Kurt Baier who says a comatose "human individual may have no qualitative life and so nothing may be a good (or evil) to him" (1979, 167), quoted in Rolston (1982, 341). What we do and what is done to us matters in ways that go beyond that which we experience or not, as Nozick's "experience machine" thought experiment illustratively teaches us (Nozick 1974, 42–45).

[110] The same is true of being harmed; one need not be aware of the harm in question to be harmed.

[111] I owe these points to Tollefsen (Tollefsen 2010, 217–18).

raises: do the anencephalic child and the PVS patient fall into a different species category or none at all? If so, then they still cannot be called "defective" or "injured" humans for they are not human at all. If they are members of a different species, then what we have is *absence* of mental capacity, not a *deprivation*, because the subject of deprivation — the human being — no longer exists. But then what else could these "lacking" individuals be but organisms of some sort? Note the oddness of there being a human organism *as a whole* lying there in the hospital bed the moment before it loses the relevant capacities, and then suddenly goes out of existence and is instantly replaced by a similar looking organism *as a whole*. To be sure, an argument from oddness is not sufficient to undermine this as a consistent metaphysical thesis and no amount of empirical evidence is going to determine whether or not this is the case. Yet Ockham's Razor should lead us to adopt a simpler explanation: there is a human being there that is profoundly disabled, because it lacks the ability to activate its ultimate capacities for rational action (Eberl 2011, 15).

Nor are we in a good enough epistemic position to place the PVS patient and the anencephalic child in the same category as the brain-dead body. The fact is our diagnostic tests for anencephaly and PVS are not reliable enough to confirm these conditions (see Shewmon, Holmes, and Byrne 1999; Merker 2007 for details). Since the (drastic) outcome for such individuals is essentially binary — life or death — we need a reliable method for sorting out the humans from the non-humans by criteria that clearly and fairly discriminate among them. Yet it is difficult to establish this solely on the degree of incapacity one might display; some would be in and others out on the basis of negligible differences, which is unjust. We should not presume such individuals are guilty of failing

the test of species membership on such flimsy grounds. In short, we have reason to believe that such individuals remain "rational animals" until they die.

In any event, the answer to McMahan's question (2008, 88), "What reason is there to suppose that all human beings are in fact internally directed or programmed toward the development of a rational nature?" is this: they would not be human beings if they were not so directed. One may consistently "dehumanize" them, alright, but not with sufficient evidence nor without dubious metaphysics.

4.2.3 On species membership and other objections

Obviously, the criterion for species membership I am working with is essentially metaphysical, and not merely biological. If we have an affirmative answer to the question, "Is this a rational animal," then we can say "This is human" — even if the subject before us is a Martian. No doubt, this is a counter-intuitive claim but the reason it is counter-intuitive is benign. It is simply a matter of convention, albeit one informed by some long-standing biological observations, that "human" refers to all and only *homo sapiens* from planet Earth; but it does not have to *only* refer to them. As David Oderberg explains:

> If we remove the fixation on biology (supplemented by chemistry and other natural sciences) as the source of all knowledge of what it is to be human, we remove the supposed self-evidence of the idea that rational animals without what we think of as the specifically human body plan or genotype would not be human. Further, if we place the appropriate emphasis on *rationality* we will have more reason to see ranimals [his word for Martians, etc.] as human (2007, 105).

Given this sort of view, the problem of "speciesism" can be avoided since what is problematic about it is the assumption that only biological concepts of species are relevant for determining moral status and they are not; what matters is the metaphysical

concept. If we are still hesitant to classify Martians as "human," then so be it: all that matters is that we classify them as rational animals, for that is sufficient to determine their moral status.

An objection to this line of reasoning is what might be called the "Anything you can do, an animal can do also" objection. According to this objection, once we start moving upward in a hierarchy of capacities, we will have trouble drawing sharp boundaries between human beings and non-human and animals and perhaps even insects. Who is to say that a dog or a cat or even a spider lacks ultimate capacities for rational action, and that all that is needed to actualize them is some not-yet-discovered procedure?[112] McMahan's articulation of this objection is representative:

> [I]f it is physically possible, through some as-yet-undiscovered form of genetic therapy, to augment a defective fetus's brain in a way that will enhance its future cognitive capacities, it is surely physically possible to achieve the same result in an animal-for example, a dog. If, therefore, we claim that a fetus with cerebral deficits is a potential person on the ground that it is physically possible for its brain to develop in ways that would be identity-preserving and would overcome or repair the deficits, we must concede that a dog is a potential person for the same reason (2002, 312).

While it may be far-fetched to think that there really could be talking beasts like we find C.S. Lewis' Narnia, the point is that McMahan and Singer need not be committed to the claim that anencephalic babies and PVS patients lack the potential for rational action at *every* level; rather, they need only affirm that these individuals lack some relevant level of potential, which functions as a threshold for determining moral status. A dilemma,

[112] McMahan advocates for dogs (McMahan 2002, 302–29), Tooley for cats (1983, 191), and Boonin for spiders (Boonin 2002, 23–24). For an extended criticism of this objection, see DiSilvestro (DiSilvestro 2010, 108:146–64).

then, appears to remain for my position: either embrace the moral status of the whole animal kingdom or accept the charge of speciesism.

In response, the first thing to say is that this objection succeeds only if it really is physically possible to alter the constitution of a non-human animal in an identity-preserving way so that it will be able to engage in rational action. Why should we believe that? Nor should the extent of metaphysical generosity given to non-human animals for possibly bearing basic capacities for rational action end with capacities for rational action. Why not also suppose that it is physically possible to alter the constitution of, say, a cow in an identity-preserving way so that it will be able to jump over the moon? If we are inclined against such ontological promiscuousness, it is because we think there is something deeper and more stable within the bovine nature that does not permit such identity-preserving changes. If this were not the case, then there would be no reason why we should not think that inanimate objects could be changed in an identity-preserving way into rational animals. No doubt, critics would be skeptical of this for the same reasons they are skeptical of the claim that PVS patients and anencephalic children are rational animals. There are what DiSilvestro calls "modal boundaries" that cannot be crossed. As he explains:

> There are innumerable ways that an entity can be modified, but an entity's modal boundary is the metaphysical line beyond which that entity cannot go. For example, the caterpillars we are aware of would cross their modal boundary if they changed into puppies. But the caterpillars we are aware of do not cross their modal boundary merely by changing into butterflies. On the other hand, if we discovered a group of organisms that looked like caterpillars, but that changed into puppies, we would not say that these organisms were caterpillars that had crossed their modal boundaries. We would say that they were not caterpillars at all: perhaps we would call them "scatterpillars". Even the character from Greek mythology named Proteus had his modal boundaries: even though he could take on the typical capacities of a donkey, and then take on the typical capacities of a human, and so on, still, he could not become omnipresent, omniscient, and omnipotent (DiSilvestro 2010, 108:159).

In any case, why should we think that the modal boundaries of cats and dogs are on par with the modal boundaries PVS patients and anencephalic children? Suppose that it is in the nature of cats and dogs to have a capacity for rational action; why do we not, then, characterize them with a pathological label (defective, injured, disabled, ill, etc.) when these capacities fail to develop? It cannot be because of the statistically regular fact that they never happen to develop these capacities. If it suddenly became statistically certain that everyone from now on would be born infertile like in the dystopian novel *The Children of Men* (James 1992), it would not change the fact that human beings are supposed to reproduce. Nor would it change the fact, assuming that cats and dogs have a rational nature, that they are supposed to think, even if it is statistically certain that none ever will. Aristotle's insight about the different senses of "deprivation" should motivate us to classify such animals as unhealthy; the fact they are not counts against the belief that they fundamentally lack the basic capacities for rational action.

Another problem with this objection is that it assumes an ambiguous concept of potentiality. While it may be the case that it is physically possible for *a* to *F* provided that *a* has the potential for *F*, it is not necessarily the case that *a* has the potential for *F* if it is

physically possible for *a* to *F*.[113] Consider again Aristotle's mole; let us suppose that it is "physically possible" for the mole to see by way of some yet-to-be discovered technology. It does not follow that the mole has the kind of potential to see that I am talking about, an *active potential intrinsic to its kind that is internally directed by its own nature* to see. In the imagined case the mole is made to see, *in spite of* its nature, which is not internally directed towards the development of sight. My argument requires that only *active* capacities for rational action are sufficient for moral status. That there may be a *passive* capacity in place to receive active capacities for rational action is not — it is a misrepresentation of my view to suppose that it does.

What to make of the objection that "permanent" changes make all the difference, and that the temporary change argument fails to address them? The key to answering this question begins with another question: what exactly changes in the "permanent" scenarios? It is not the nature of the human being before us, as I have argued. The distinctive feature of "permanent" cases is that we do not have the medical know-how to reverse the conditions of anencephaly or those that cause a PVS. Indeed, "permanence" turns out to be a tricky concept, which is nicely illustrated in the writings of the 1983 report of the President's Commission. In their guidelines for deciding when to forego life-sustaining treatment, the Commission wrestled with how to interpret 'permanence' deciding, on the one hand, that it is better to say that one is 'permanently unconscious' than 'irreversibly unconscious' so as to avoid conflating a state like a PVS with

[113] I am uncertain as to whether physical possibility is a necessary condition of potentiality. In one sense, it is "physically impossible" for a pigeon forced to live in a cage all its life to fly, and yet, by virtue of being *what it is*, the pigeon has the basic, though undeveloped, capacity to fly (President's Council 2002, 178). But I will assume it is for the sake of argument.

"irreversible coma" which was identified with whole-brain death by the 1968 Harvard Ad Hoc Committee (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983, 179 n13). On the other hand, their rationale for rejecting the phrase 'judged to be permanent,' is that the element of "probabilistic judgment" is essential to "every scientific prognostication" and "redundant and unnecessarily awkward" (Ibid.). So, it seems "permanence" implies an "irreversible" state that has a small probability of reversing. Awkward as that may be, what the Commission was getting at is that it may be metaphysically possible to reverse someone's unconscious condition, but it will not happen for contingent reasons. That is to say, a permanent condition of unconsciousness is one that *can*, but *will not* be reversed, because we lack the technical resources for how to reverse it and will continue to do so for the foreseeable future. Clearly, then, none of this implies that the permanently unconscious patient lacks the ultimate capacity for rational action any more than someone under anesthesia that will die in the next minute from a falling meteor. The temporary change argument is concerned with the metaphysically possible conditions that assume (for conditional proof) enough time and technical know-how are operative to make the desired changes, not the actual conditions.

Nevertheless, some think that the possession of basic active capacities for rational action is not ethically significant in itself, and that the degree of the remoteness or nearness of their actualization is. John Lizza offers the following thought experiment to illustrate why:

> For example, suppose that we have the knowledge and technology to clone the skin cell but lack the knowledge and technology to correct the genetic defect in the anencephalic embryo. Suppose further that we had some dire need to increase

> the human population and that the cloning technology was in very limited supply. Even though the anencephalic embryo might be said in Shewmon's view to have the active potential for intellect and will with assistance, we would not value it as much as the skin cell and cloning technology that could "produce" a human being. If one had to perform triage and devote resources to either the anencephalic embryo or the skin cell, it would be ethically justified to devote those resources to the skin cell rather than to the embryo (Lizza 2011, 26).[114]

While I am not sure there are such things as "anencephalic embryos," Lizza's implication is clear: the value of one's potentiality for rational action, whether it be active or passive, depends on the likelihood of its being realized.[115] To be sure, the time it might take for someone to recover is going to factor into what sort of treatment options, if any, we might choose. Yet we should not assume that potentiality only has instrumental worth and should not be taken as evidence of intrinsic worth, for reasons already stated: if I am now under anesthesia and will not wake up for another hour, and it is true that I will be killed by a falling meteor five minutes from now, I still retain my non-instrumental worth. The contingent certainty of me not "coming back" is simply irrelevant as to whether I have moral status or not. Another way of stating the problem is that Lizza assumes that the ethical significance of human potentiality is exhausted by what its actualization *becomes*, i.e. a person, and therefore its importance depends on when and if, its actualization will occur. But active capacities for rational action that are intrinsic to a thing are constitutive of a thing's *being*. That is to say, they indicate what the thing *is*, and help explain why it might have non-instrumental worth regardless of its circumstances — even circumstances

[114] One of the odd things about Lizza's paper is that he charges theories of potentiality like mine with the problem that it cannot adjudicate borderline cases in a non-arbitrary way. This is puzzling, because if it could adjudicate "borderline" cases in a non-arbitrary way, then they would not be borderline cases at all. Borderline cases are essentially indeterminate. I would think it is worse if a theory gets the wrong results, which Lizza's theory certainly does (as aptly demonstrated by Eberl [2011, 16]).

[115] Nicholas Wolterstorff is another thinker who thinks the appeal to higher-level capacities is "unimpressive" though he does not say why (2008, 333). If this were the case, there would be no concern whatsoever over medical experiments that destroy human embryos. But there is, so it's not.

where it might be better to invest limited resources in cloning a skin cell over preserving an "anencephalic embryo".

Lizza is surely right when he observes that disagreement over the nature of potentiality and its moral significance depends, in part, on the view of human persons we assume (see his 2010). Of course, he believes that anencephalic children and PVS patients are not persons at all, and that no human organism is identical with a person. A human organism's potential to become a person, then, is only valuable only insofar as it is likely that the organism will *constitute* a person. Thus, human organisms that fail to constitute persons are "potential persons" *at best*.[116] Yet on my view, human beings are "persons with potential" *at least*. The reason why, as I have argued, is that we not only have the basic capacity for rational action, but that we also have the basic capacity to live a biological human life. Our life began at fertilization (or twinning), we grew inside our mothers, we were fed and had our diapers changed when we were newborns, and we grew up to be smart enough to read this text. Lizza denies this conjunctive claim, but he and I agree that the ethical significance of potentiality depends on the nature of human persons; and I have already criticized his view and defended mine at length in Chapter 2.

4.3 Is a "respect for donor" rule different from a "dead donor" rule?

A final objection worth considering to my thesis (that killing someone for their organs disrespects the worth of someone) is that I misunderstand the true nature of respect. As Elysa Koppelman claims,

[116] The same is true of the views espoused by Singer, McMahan, Tooley, and Boonin.

> By applying the [DDR], we are failing to help patients achieve the fate that best fulfills their personhood. And this failure, especially given the implications of medical progress, reflects a moral cowardice and an abdication of our common humanity. By changing our focus we will realize that life and death distinctions are not always compatible with respect for persons (2003, 7).

She reaches this conclusion through an argument, which can be formalized like so:

1. If a person has indicated that she wants to be an organ donor, and forgo life-sustaining treatment when brain-dead or in a PVS, then denying her the opportunity to donate in these circumstances harms her.
2. This harm is a form of disrespect.
3. Therefore, any person who is denied the opportunity to donate in these circumstances is disrespected.

Because the DDR is the source of disrespect, she calls for its replacement with the "respect for donor rule," which takes into account a patient's life history, decisions, and values, not whether they are dead or alive. This, in her view, is a more holistic view of human personhood. Instead of focusing on the characteristics one might have at a given moment, like one's potential capacities for rational action, one's ends as set by the person and one's life history as shaped by the person, including the directives for what others are to do after death or incapacitation, is more important. These things, she thinks, are the substance of our shared humanity, and not the mere possession of a rational nature. So, if one's life history includes directives to be volunteered for transplant surgery while alive, but whose unconsciousness is medically irreversible, then the ethics of respect generate a duty in others to honor them. Failing to honor them, results in the "moral cowardice" and "the abdication of our common humanity" that she speaks of.

A close inspection of her argument, however, reveals a dilemma: either all parties to this debate can agree with its premises rendering it trivial, or it trades on a controversial reading of "opportunity to donate" rendering it ambiguous. Even one who

denies that brain death is death can agree with her conclusion if the "opportunity to donate" merely refers to working with a transplant team to deploy standard procedures that remove vital organs after a determination of death by circulatory criteria. This, of course, is compatible with the DDR, which is contrary to Koppelman's assumptions. To make her conclusion incompatible with the DDR, we must take "opportunity to donate" to refer to the opportunity to be killed on the operating table by one's transplant surgeons. But is it really the case that one is *disrespected* if one is denied this opportunity?

Supposing for a moment that her conclusion is true in this controversial sense, it follows that the transplant community is *obligated* to kill the donor, which is simply false. This is because norms of respect generate rights-claims on behalf of the one who is owed respect, and rights entail obligations. Yet no one is obligated to kill her. The problem for Koppelman's "respect for donor rule" is that it ends up demanding over-respect; it effectively nullifies the autonomy of transplant surgeons *not* to engage in mortal harvesting. What Koppelman needs is an argument that reaches a weaker conclusion: that transplant surgeons are merely *permitted* to kill donors under such circumstances, not that they are *obligated* to do so.

This is no problem for her if she assumes (and she does) that the life of a PVS patient is of such a low worth that it no longer deserves protection from being killed through the framework of informed consent. If she wants to exclude healthy people from the donor pool (and she does), then she must answer the question as to what gives life its worth, such that it should not be killed even upon request. Koppelman's answer is the well-worn psychological property of being capable of forming desires and interests (Ibid., 8; cf. Zohar 2003, 12). Contrasting the PVS patient, (whom she permits to be killed) with

the severe Alzheimer's patient (whom she does not), she writes, "There isn't really anything that being in such a state [the vegetative state] is like, for being in such a state is like being in no state at all" (Ibid.). Of course, the same is true of being under anesthesia or in a deep sleep: there is no felt experience of those states either. Clearly, what matters is some level of capacity to get out of these states, but then we are back on the wheel: what level of capacity for these things is morally relevant? I argue that, for any non-ultimate level of capacity we choose, we can envision a temporary change scenario where one redevelops the capacities relevant for moral status, and therefore had moral status all along. Without giving an argument for why we should believe PVS patients have no ultimate active capacity for rational action, we cannot safely claim that they lack moral status, which, again, is contrary to her assumptions.

Koppelman's preferred way to limit the autonomy of healthy people in order to avoid respecting their death wishes only serves to bolster my point about the moral relevance of basic, natural capacities. As one who is sympathetic with Kant's moral framework, Koppelman believes "it can be argued that the end of giving vital organs when not in a suspended state [i.e. being brain-dead or in a PVS] is almost always irrational or immoral, while the end of giving vital organs when in such a state is not" (Ibid., 8). Although she gives no argument, I suspect that she finds something compelling in Kant's argument that we should not respect a suicidal will since it seeks to annihilate the very thing that merits respect: a will that is capable of setting ends for oneself.[117] Kant's point is that an autonomy-based right to withdraw oneself from all the duties of

[117] See Cholbi (2000) for an excellent overview of this argument.

respect one is owed involves a contradiction (Kant 1964, 84). The reason is that we cannot divest ourselves of our worth by virtue of exercising the capacities that give us our worth. So, if PVS patients no longer have this capacity, then their wishes to die by transplant surgery as indicated beforehand generates no paradox of autonomy in which one wills both to be respected and annihilated. Yet even if we grant that the thrust of Kant's argument is largely correct (and I think it is), Koppelman begs the question with respect to whether PVS patient's actually have the capacity for rational action *at some level or other*. I say they do, for if they did not, they we could not intelligibly understand them to be injured. Therefore, we should not assume that donors can consent — even in advanced directives (*pace* Cochrane and Bianchi 2011) — to be treated in a way that makes their lives comparably less valuable than their organs, and as a mere receptacle of coveted pieces of tissues that can be mined for beneficial purposes. This is what is fundamentally wrong with mortal harvesting.

4.4 The basis of human equality

Let us take stock. Essentially, my argument is that if anything has the set of basic capacities for rational action, it has moral status; all human beings have this set no matter their maturity level or disability status; therefore, all human beings have moral status — what I call 'dignity' — which makes them objects of respect. This argument was made with a view towards providing a basis for human equality. Any basis that depends on properties that come in degrees is flimsy at best. The chief virtue of Jeff McMahan's work is that he has shown that our liberal egalitarian principles must be revised if we are to make one's moral status depend on the exemplification of certain psychological properties. To his very great credit, this is something he recognizes (e.g. 2008, 104), and

with great intellectual integrity, he is willing to follow his principles where they lead. In particular, he is willing to claim that killing a *healthy* orphaned newborn infant for its organs is permissible, since he thinks a newborn's "psychological connectedness" is not strong enough to generate a time-relative interest in continuing to live.[118] He is worth quoting at length:

> Suppose that a woman who wants to be a single parent becomes impregnated via artificial insemination, but dies during childbirth. She has no close friends and no family — no one to claim the child. The newborn infant is healthy and so is an ideal candidate for adoption. But suppose that, in the same hospital in which the infant is born, there are three other children, all five years old, who will soon die if they do not receive organ transplants. The newly orphaned infant turns out to have exactly the right tissue type: if it were killed, its organs could be used to save the three ailing children. According to the view I have developed, it ought to be permissible, if other things are equal, to sacrifice the newborn orphaned infant in order to save the other three children (2002, 359; cf. 2007, 152).

This frank acknowledgment appears in a discussion of troubling implications that function as reasons to reject his view altogether. Nonetheless, he is willing to bite the bullet, because he thinks not biting it leads to morally inconsistent positions, specifically with respect to how we treat certain animals (McMahan 2013). Since I refuse to accept this, I have labored to develop an alternative account of the nature of human beings and a morally consistent view of the wrongness of killing to support my judgment.[119] Those

---

[118] McMahan distinguishes between interests and time-relative interests, because he does not think identity is the basis of rational egoistic concern. He says,

> One's time-relative interests are always, as the label is intended to suggest, relativized to one's state at a time. They are different from one's interests (as traditionally understood) in that they are affected by the strength of the prospective prudential unity relations whereas one's interests are not. One's interests are concerned with what would be better or worse for oneself as a temporally extended being; they reflect what would be better or worse for one's life as a whole. If identity were the basis of rational egoistic concern, there could be no divergence between one's interests and one's time-relative interests (2002, 80).

[119] A clear way of expressing the disagreement between McMahan and I goes like this: he thinks it is *more* counter-intuitive to believe that a day-old embryo is entitled to the same protections from being killed as those of us who can read this text *than* it is to believe that killing an orphaned healthy newborn infant for its organs is permissible — I do not.

who attach moral status to psychological properties that come in degrees should take heed, because more is at stake than we realize. The egalitarian principles, so cherished in Western societies, that have been foundational to democracy and an impetus for much progress are at risk of being undermined.

By contrast, my view implies that the moral status we have in virtue of being rational animals is one that does *not* come in degrees. This is precisely what our egalitarian principles require, and they are elegantly satisfied by an all-or-nothing property: the possession of a rational nature. Those that have a rational nature have a non-instrumental worth I call "human dignity" Human dignity is inherent and ineliminable, and there is a duty to respect it at every stage of development or at any degree of (non-ultimate) incapacity throughout human life. While some may be discomforted by the "conservative" implications this view may have for the practices of abortion, embryonic stem cell research, euthanasia, and physician-assisted suicide, I am happy to embrace those implications.[120] One should see my position as resonating with the ethical forecast given by G.B. Giertz at the 1966 Ciba meeting (see Chapter 1). As he saw it, "respect for the value of the human being and hence democracy is in danger" when a society embraces social practices that deny "that every human life, even the most wretched, has a meaning" — or human dignity, as I put it (Giertz 1966, 140).

[120] Though I should also say that "liberals" ought to deny that the permissibility of voluntary euthanasia entails the permissibility of voluntary "organ donation" euthanasia. Standard euthanasia practices are typically justified by an appeal to the patient's "dignity" in death (a dignity that is grounded in autonomy), and that one must respected as an end in the choice to die by a painless lethal intervention. But if dignity is grounded in autonomy, then a "paradox of autonomy" remains for mortal harvesting policies, since they require the donor to consent to being used as a "tissue bank" that can be killed for utilitarian benefit, and not purely for the patient's own sake.

Nonetheless, the view that human beings have some sort of non-instrumental worth by virtue of what they are, and what they are is determined by their ultimate capacities for rational action, shares a surprising amount of common ground among philosophers of divergent political persuasions. The so-called "capabilities approach" that recognizes the moral significance of the freedom to pursue one's flourishing, and that one's opportunity to do so is best understood in terms of their capabilities (or capacities), is one that is interpreted in various ways through Rawlsian and Aristotelian lenses (Robeyns 2016). Early in her development of the relation between human capabilities and human rights, Martha Nussbaum (a political liberal) notes that one of the senses of "capabilities" she is working with is called "basic capabilities" — "the innate equipment of individuals that is the necessary basis for developing the more advanced capability" (1997, 289).[121] Similarly, to account for the notion that each of us possesses an ineliminable human dignity, Robert George and Patrick Lee (political conservatives) appeal to the notion of a "basic natural capacity" for conceptual thought that "human beings have in virtue of the kind of thing they are" (Lee and George 2008b, 185). While I tend to side with Lee and George regarding the implications for the ethics of killing, it is

[121] Nussbaum has since dropped this conception of basic capability, because, in her view, it does not adequately secure the political equality of those with severe mental and cognitive disabilities. She says, "that it is quite crucial not to base the ascription of human dignity on any single 'basic capability (rationality, for example), since this excludes from human dignity many human beings with severe mental disabilities" (Nussbaum 2008, 362). Yet she makes the same mistake Singer and McMahan make; concepts like "severe mental disability" cannot attributed to human beings unless the human form essentially includes the basic capacity for rationality and so forth. Another problem is that she posits some arbitrary and unspecified minimal threshold one must meet for being capable of engaging in "major human life-activities" (Ibid., 363). Hence, PVS patients and anencephalic children don't make the cut in her view, "since it would appear that there is no striving there, no reaching out for functioning" (Ibid.). Yet if we are just going by appearances, the same could have been said of Terry Wallis, someone who clearly had equal dignity while in his non-responsive state. Therefore, Nussbaum's revised view of human dignity should be rejected for the same reasons McMahan's and Singer's should be rejected: it is arbitrary, unfair, and rests upon metaphysical confusion.

striking how prominent the agreement is that basic capacities (or "capabilities") for rational action are foundational to our egalitarian principles. And it is a good thing too. For it gives us a principled reason to care for a healthy orphaned newborn infant, and soundly reject as impermissible the proposal to kill it for its organs.

4.5 Mortal harvesting is incompatible with human equality

What often goes unnoticed in cases for mortal harvesting is how inimical they are to the notion of human equality. Common to every proposal is the proposition that the organs inside a potential donor are more valuable than the life of the donor. For example, although Miller and Truog believe no one would be made dead by mortal harvesting who would not otherwise be made dead by withdrawing life-support, they readily acknowledge that some patients will die by transplant surgery who would otherwise continue to live because of our imperfect ability to prognosticate death after the withdrawal of life-support (2012, 116). They are willing to accept this risk, however, in light of the benefits that would come to organ recipients as well as the respect for the wishes of the donor to donate. What they are not willing to risk, however, is possibly damaging the organs from warm ischemia in a protocol that would begin surgery after withdrawing life-sustaining treatment and waiting for asystole to occur (Ibid., 121). Consequently, their view implies that the risk of harming the organs outweighs the risk of harming the donor, something that is at odds with the longstanding norm that protecting the donor from harm should take precedence over protecting the organs from harm. Of course, the only senses of "harm" they care about is the experience of pain or a setback to one's interests; intending the destruction of another's being is of no concern to them. This should not be the case.

To be sure, the value of the organs in proposals like Miller and Truog's is derived from the value the donor and recipient places on them. Yet this just reveals that one's life may be medically sacrificed for the sake of another, owing to the assumption that the donor's life is not worthy of protection from being instrumentalized to the point of death. Potential donors, who are deemed "terminally ill" (Verheijde, Rady, and McGregor 2007), or "as good as dead" (Miller and Truog 2012, 144–47), or to have "no hope of meaningful recovery" (Glannon 2013), are empowered to consent to their deaths via transplant surgery while those who fall outside these categories, are not. Since we expect people to be rational, those who refrain from undergoing mortal harvesting must give some reason to do so upon pain of irrationality, which is an intellectual burden no healthy person has to bear, and is therefore unfair (see the argument of Velleman 1992 again).

The choice to refrain is not only burdened intellectually, but also morally. Given that every argument for mortal harvesting references the dire need for organs, this empowerment to die by transplant surgery quickly moves to an imperative that is all too easy to justify. One could use the framework of Peter Singer's "Famine, Affluence, and Morality" (1972) argument to reasonably conclude that you act immorally if you are "terminal" or "hopeless" or "as good as dead" and you refrain from "organ donation euthanasia." Formulating the argument makes this clear:

1. Suffering and death from the lack of a transplantable organ is bad.
2. If it is in your power to prevent something bad from happening, without giving up anything as equally important, it is wrong not to do so.
3. If you are "terminal" or "hopeless" or "as good as dead" and if you refrain from donating, then it is in your power to prevent suffering and death by donating a transplantable organ, without sacrificing anything nearly as important.
4. Therefore, if you are "terminal" or "hopeless" or "as good as dead" and if you refrain from donating, then it is wrong to do so.

All parties to the debate agree with the first premise. Nearly everyone agrees with the second, as it seems perfectly wasteful to forbid transplants from freshly-dead bodies (e.g. Fletcher 1968); yet, the third is precisely what is at issue. Mortal harvesting could not be justified as a matter of public policy without affirming it, and potential donors would be saddled with its moral stigma despite being permitted to refrain from sacrificing their lives. Now, a potential donor could invoke what I have argued for here, that *there is* something that would be sacrificed that is just as important, that is, the inherent dignity of the individual human person. While I believe this is a good reason for a potential donor to refrain from undergoing mortal harvesting, the point is that no potential donor should have to bear the weight of rebutting this (question-begging) argument, which just assumes, as a matter of policy, that this not a good reason.

Worse yet, policy makers who would establish mortal-harvesting practices seem indifferent to the fact that a certain set of quality of life judgments along with their lethal implications would become a systematic part of the transplant enterprise. No doubt, these judgments are already tacitly involved, but it does not follow that they should be involved as a matter of policy and that this would somehow be an improvement over the status quo (being honest about an evil practice is no virtue). For if we were to adopt these proposals, then there is no reason why we should not be able to lethally experiment on the same class of people, so long as they consent to being used lethally for the sake of gaining medical knowledge. This, of course, would undo the fundamental ethical principles laid down by the Nuremburg Code, the Declaration of Helsinki, and the Belmont Report. To allow mortal harvesting is not to just "rethink" the ethics of death, dying, and organ

transplantation, but the whole bioethical enterprise itself. Are advocates of mortal harvesting prepared to go as far as their principles will take them? If not, why not?

4.6 Conclusion

I opened this chapter with two epigraphs, one from Joseph Fletcher (Bard and Fletcher 1968, 64) and the other from John Paul II (1995, 102) so as to contrast the implications of two very different views of human life. On the one hand, there is Fletcher's view, which makes life's worth wholly dependent upon the likelihood of actualizing certain psychological capacities constitutive of (neo-Lockean?) "personhood." What degree of instantiation is required for personhood is anyone's guess, but it is clear that one can be born an "idiot" — Fletcher's charming term for people with Down's Syndrome — and be kept from living. To allow for such a life, on his view, would be to incur some vague and unspecified sort of guilt. On the other hand, there is the Pope's view, which simply identifies human animals with "persons" and ascribes "absolute equality" to every one of them. The opportunity to flourish for an eighteen-year-old man matters no more (or less) than it does for a day-old female human embryo. One might be tempted to think of these views as two unacceptable extremes, and that there should be some safe middle ground that avoids the moral implications of each. It is a reasonable thought. Certainly, a view like McMahan's does not automatically count babies with Down's Syndrome as being life unworthy of life.[122] Nonetheless, such views place a

[122] Though I have been critical of him, I must draw attention to his admirable courage in confronting the case he describes in the following:

> I recall once being consulted by a hospital's ethics committee about a similar case. A woman in the late stages of pregnancy had been told that her fetus had been discovered to have Down's syndrome and a heart condition that would be fatal within the first year unless it underwent a major surgery that would have a reasonably high probability of success (I think, though my recollection is dim, around 70%). The parents were opposed to abortion on religious grounds and thus said that they preferred to

burden of proof on such babies as to whether they will likely display a sufficient amount of "psychological connectedness" to merit some form of respect. This is precisely what we should expect of views that make one's moral status depend on the instantiation of certain psychological properties that can only come in degrees. Nor can we avoid the problems of arbitrariness and injustice by positing some threshold of respect to make moral status an all-or-nothing category. Even if we could draw the line in a reasonable place, some are in and out on the basis of negligible differences with grave consequences.

The just alternative is to identify moral status with something that does not come in degrees, that is, a being's *nature*, specifically a rational nature.[123] On this view, our dignity is bound up with our way of *being* rather than our way of *becoming*. If you are an individual substance with a rational nature, you have moral status; every human being is such a substance, so every one of them has moral status. Concomitant to this belief is that our dignity is ineliminable, which makes it the case that our suffering always matters no matter how terrible it may be or how insentient we may become. The deep implication of this view is that we are not merely receptacles of "value" whose claim to life wholly depends on whether we can be the subject of some good state of affairs or pleasurable

---

> continue the pregnancy; but they also wanted to decline the surgery, allegedly because they wanted to spare the infant the suffering that would be involved. The other members of the committee — physicians, a nurse, a priest, a rabbi and a lawyer — all thought this was an acceptable solution. I pointed out that no one would think it acceptable to forgo the surgery if the infant did not have Down's syndrome or if a similar heart condition requiring similar surgery were not diagnosed until the child was a year or two old. I suspect that it was because I had implied, especially in the presence of a lawyer, that the committee was endorsing the view that an individual could be allowed to die because of a disability that I was never again invited to serve as an ethics consultant at the hospital (2013, 275).

Of course, his wisdom in highlighting this case of ableism is only meant to serve his broader point, that *all* infants are equal candidates for infanticide so long as some set of relevant conditions are met — like being orphaned and a perfect tissue match for those who are in need of a healthy organ, and healthy enough to supply them.

[123] For a fine argument along these lines see Lee (2015).

sensation. Modern accounts of killing tend to reduce human worth to the degree of happy properties one contingently exemplifies, and leave our natural, intrinsic dignity behind. "They are," as Timothy Chappell says, "metaphysically superficial, because these accounts focus on what's secondary, the properties of the individual person, while ignoring or bypassing the primary thing, the person herself" (2004, 108). Perhaps this is a consequence of our culture's move towards secularization, which leaves behind the idea that human beings are made in the image God. Geirtz certainly thought this when he remarked at the Ciba meeting that "The concept of unconditional human worth cannot, however, be justified rationally" (1966, 144) — the implication being that it could only be accepted as a matter of blind faith. My hope is that the reader will see, that after examining the contents of this chapter, that it can be accepted rationally. Once it is accepted, we can see that killing someone for their organs is disrespectful of the worth of the one being killed.

Chapter 5: In Defense of the Absolutist's Answer

Abstract: This final chapter concerns the nature of respect as it appears in the fourth and fifth premise of my master argument. I assume, as a formal matter, that no act that disrespects the worth of a person is permissible, because what counts as a material act of disrespect depends on the value theory and fundamental moral principles we assume. In any case, those things are violated if an act of disrespect occurs. Hence, a consequentialist whose idea of respect is bound up with giving due consideration to everyone's interests could affirm the fifth premise while denying the fourth. By contrast, I defend the Absolutist's Answer: we should *always* and *everywhere* refrain from intentionally destroying the donor, someone who is an innocent subject of dignity.

"I am concerned not so much with what rights people have, but with what we ought to do. It may be that we ought not respect rights if the cost of doing so is this high or, perhaps, that we ought to revise our system of rights."

—John Harris

"Tell me yourself, I challenge your answer. Imagine that you are creating a fabric of human destiny with the object of making men happy in the end, giving them peace and rest at last, but that it was essential and inevitable to torture to death only one tiny creature—that baby beating its breast with its fist, for instance—and to found that edifice on its unavenged tears, would you consent to be the architect on those conditions? Tell me, and tell the truth."

—Fyodor Dostoevsky

5.0 Introduction

One should be forgiven for thinking that this chapter would follow the pattern of the previous ones, and that I would offer a defense of the last premise in my master argument, that no act that disrespects the worth of a person is permissible. It would seem that this would be the hardest premise to defend, since it is a moral absolute. Merely imagining that we could avoid some horrible catastrophe simply by disrespecting someone should be enough to put the matter to rest, should it not? Perhaps this is why

formal defenses of the permissibility of disrespect are hard to come by — it is just obvious that treating someone with disrespect is sometimes justified. Yet this is too quick. What exactly counts as an act of disrespect? We might think that torturing the innocent would be a good example. Is it supposed to be obvious that any defense of such an action is thereby also a defense of an act of disrespect? I, for one, do not think it is obvious because it does not answer the question of just what constitutes an act of disrespect in the first place.

I submit that the reason no one formally defends the permissibility of disrespect is that norms of respect are grounded in the theories of value embedded in fundamental moral principles like the principle of utility, the Categorical Imperative, or the First Principle of Practical Reason. They are not norms of precepts which require, *in addition to their normative ground*, a description of a kind of action.[124] Rather, they are norms of principle. The difference is subtle, but significant and made evident when we consider the moral absoluteness of a universal principle, like the principle of utility (i.e. we must *always* maximize the good) versus the moral absoluteness of a precept concerning an action type (i.e. we must *always* refrain from torturing the innocent). The formal character of our norms of respect are wholly determined by the normative grounds we assume, particularly the theory of value which shapes our ideas about the moral status of individuals; these assumptions provide the identity conditions for material acts of disrespect. Formally, then, disrespect is always prohibited, since disrespect is always incompatible with the moral worth of the individual involved.

[124] The paradigm example of a norm of precept is the norm against murder, which is derived from a normative premise (the intentional killing the innocent is wrong) and a descriptive premise (murder is the intentional killing the innocent).

What evidence is there for this thesis? Consider someone charged with disrespecting someone else. One usually does not reply, "My act of disrespect was justified" as if there were such things as *justified* and *unjustified* acts of disrespect that could be specified apart from a fundamental theory about one's moral considerability.[125] Rather, the response is one of denial and perhaps a claim that the object of the action was treated in accordance with its worth, and that the action was somehow appropriate or deserved or that the recipient "had it coming." Indeed, to treat something with respect is to treat it in accordance with its worth; to disrespect something is to treat it as having less worth than it actually has.[126] This is part of what we find wrong with disrespect — it is a failure to appreciate things as they really are. We could not rationally treat a thing we *know* to have a certain worth as if it had less worth, and then defend our actions as "justified" as if the object in question were somehow worthy of unworthy treatment. Such a practice is simply unintelligible. Any moral justification we could offer for the subpar treatment of the object in question depends on a correct assessment of the worth of the object, something we already know and willingly disregard. What is at issue, then, are the moral theories that determine the worth of things in question, and the underlying moral principles that give shape to our norms of respect, not whether disrespect is permissible. For these reasons, I forgo a formal defense of the claim that no act that disrespects the worth of a person is permissible and instead turn to an investigation of moral theory.[127]

[125] Indeed, a fundamental theory will ultimately determine whether one is worthy of respect or not.

[126] Here I am influenced by Wolterstorff (2008, chap. 13).

[127] If the reader thinks what I've said here is far too quick and underdeveloped, I can only plead for patience; a better sense of why I frame things this way will emerge throughout the rest of the chapter.

What is of particular interest to me is what the extent of the norm against disrespect implies and whether it can be "outweighed" or "overridden" by some other moral consideration. The problem is a familiar one. There is wide agreement that the autonomous choices of patients should be respected. There is also wide agreement that such choices should not be honored if they would cause great harm to oneself or others. Take participation in a Phase I drug trial, for example. Suppose Sally gives valid consent to participate in the trial, but is forbidden to participate because she would be greatly harmed by doing so. Has her autonomy been respected or not? One could characterize the investigators as disrespecting Sally's autonomy for the greater good, something that implies a sense of moral disapproval. Yet it is hard to believe that what the physician-investigators do is wrong; in fact, there is a more charitable way of evaluating their actions. We can say they took Sally's interests into consideration, weighed them against the risk of harming her, and judged that the risk of harming her was of greater concern than honoring her wishes. This does not imply that they disrespected her autonomy. That they took her wishes into consideration and weighed them carefully against other relevant moral factors appears to be sufficient for treating her autonomy with respect.

This could have devastating implications for my argument. One might object to my claim that killing the donor for their organs disrespects the intrinsic worth of the donor by giving the following argument:

> I acknowledge the intrinsic worth of human life and the dignity inherent in every human being and I have taken those things into consideration. However, I have also taken into consideration the interests of donors who would consent to dying by transplant surgery, and the lives of the recipients who would benefit from receiving a healthy organ. Indeed, I have given *equal* consideration to all these things, something you have failed to do. On balance, I have determined, that the concern for the intrinsic worth of the donor's life can be overridden for the sake

> of respecting the donor's autonomy and benefitting the lives of the recipients. By contrast your narrow commitment to respecting the intrinsic worth of the donor above all else fails to respect donor autonomy and harms potential recipients. In fact, you could say that I have a greater sense of respect for human life than you do, because I factor the individual lives of the potential recipients into my evaluation, and you do not. If anything, you are committing an act of disrespect toward the worth of human beings, not me.

One issue here is the nature of respect. The question is whether A treats B with respect *provided that* A gives B due consideration. We can grant that giving due consideration is necessary for respect; but is it sufficient? Or is something more required? Specifically, must we, in some cases, refrain from *destroying* the object of respect? Another issue is whether human worth adds up. Does the intrinsic dignity each individual possesses "count as one and no more than one," as Bentham might say (quoted in Rosen 2005, 228), so that we are permitted to destroy Sally (assuming she consents to being destroyed) to save Tom, Dick, and Mary? The loss of three dignity-bearing human beings clearly seems worse than the loss of one. At least from an economic standpoint, no one is made worse off and everyone involved gets what they want. Sally gets to give up her life, a life she no longer wants to live, and Tom, Dick, and Mary get to go on living lives they want to live. This raises yet another issue: how should the interests of everyone involved be counted and *can* they be weighed against the worth of human beings themselves?

I intend to defend what I will call the Absolutist's Answer: we should *always* and *everywhere* refrain from intentionally destroying the donor, someone who is an innocent subject of dignity.[128] The goal of this chapter, then, is to offer a clarification of what I

[128] One might reasonably wonder why non-innocence should make a difference to a view that bases moral status on the possession of a rational nature. If non-innocence makes a difference, then having dignity and having moral status are not coextensive. I accept the point. Here, I follow Craig Paterson (2008, 83), who suggests that it is not the intrinsic status of a good that determines whether an instance of the good should be intentionally destroyed or not; rather, it is the nature of the demands imposed on us by the

think respect for human worth entails, and defend the fourth and fifth premises of my master argument from being read ambiguously. I will begin by examining whether giving due consideration is sufficient for showing respect, and argue that such a conception of respect is essentially consequentialist in character. Second, I will argue that principlism, the reigning paradigm in bioethics today, is a species of consequentialism and that it is committed to this inadequate form of respect. Thirdly, I give some reasons why consequentialism is inadequate as a moral theory, and explore anti-consequentialist options for grounding the Absolutist's Answer. The purpose of doing so is to support the DDR as a rule that admits of no exceptions. Yet it turns out that the case for supporting the DDR as an exceptionless rule need not *logically* depend on the falsity of consequentialism. In the last section, I will explain how a rule-consequentialist could reasonably hold that the DDR is a "virtual absolute" because it is reasonable to believe that upholding it as an exceptionless rule would produce better outcomes for organ donation than not upholding would.

5.1 Equal treatment v. consideration

To summarize what I said in the last chapter, I concluded that mortal harvesting is incompatible with human equality. Some people are candidates for lethal transplant

---

particular good in question. The life of an innocent human being, which ought to be respected in virtue of its dignity, demands that it not be intentionally destroyed. The life of a non-innocent human being cannot make that demand, since the action of the non-innocent threatens the being and integrity of others who pose no threat. To protect non-innocent human life as much as innocent human life is to not protect innocent human life at all. Thus, the demands of human dignity are ordered to the protection of human beings who pose no threat to others, and the immunity from killing one enjoys in virtue of having dignity disappears when one becomes a lethal threat. We should not think, however, that the non-innocent loses their dignity by virtue of their threatening behavior. Indeed, the respect the non-innocent are due requires that the means undertaken to defend against their threat must be proportional to the threat they pose.

surgery on the basis of their health status, which is something that can only come in degrees. Those deemed "terminally ill," or as "good as dead," or "hopeless" are empowered to give up their lives for those who are not, and those who choose not to do so must be able to give a reason for their choice if they are to be counted as rational, something no healthy person has to do. Such a policy is not only unfair, but also inegalitarian in the sense that it values the lives one set of people over another set by virtue of a property that can only come in degrees — one's health status. Some would be in or out of the sphere of protection from being killed on the basis of arbitrary and negligible differences. Or so it seems to me.

Perhaps, however, I am wrong to think there is a lack of recognition of our human equality in proposals for mortal harvesting. The reason why is similar to the reason why I may be wrong about what respect entails: perhaps only due consideration of everyone involved is sufficient for equality and a further a prohibition against intending actions that would destroy them is not necessary. As Peter Singer explains, the "principle of equality" does not require giving equal treatment or granting the same rights to two different groups; rather, the principle requires giving each *equal consideration* (1975, 2). What we ought to do is take into account the interests of the being before us, whatever those might be. If we want to expand our circle of moral concern beyond the interests of sentient beings to include the objective worth of things like human dignity, the point remains the same: if a being has worth or interests there is absolutely no moral justification for refusing to take those things into consideration. Those that fail to do this do so out of ignorance, bias, or prejudice. It is only when we rid ourselves of these things and take everything into account that can we say we are satisfying the principle of

equality. Once we do that, we can begin to make decisions about what ought to be done and it may be the case that implementing policies of mortal harvesting is the right thing to do, all things considered. In any event, satisfying the constraint of equal consideration is sufficient for treating people equally since it is an application of giving due consideration to everything involved. It is a form of respect that has a maximally broadened circle of moral concern.

What this means is that human worth is only one thing among many to consider. It occupies no privileged place in our moral deliberation. The so-called "hopeless" person who wants to go on living cannot appeal to her ineliminable dignity as a *sufficient* reason to go on living in the face of the option to die by transplant surgery. Since the principle of equal consideration enjoins her to consider all things, including people just like her who need her organs, she cannot just assume that her life counts more than theirs. The same, however, is true for healthy people; *everyone* must consider the interests of those who are in need of vital organs, not just the sick. From the physician's side of things, refusing to perform lethal surgery cannot be justified simply on the basis that doing so would violate human dignity. More has to be considered. Now it may be the case that human dignity weighs very heavily. But it can be "balanced off" just if another object of human dignity is at stake. To settle "ties" one must consider the weight of the competing interests of everyone involved and the overall effect our actions will have on them.

With these things in mind, let us consider Gilbert Harman's patient in Room 306:

> You have five patients in the hospital who are dying, each in need of a separate organ. One needs a kidney, another a lung, a third a heart, and so forth. You can save all five if you take a single healthy person and remove his heart, lungs, kidneys, and so forth, to distribute to these five patients. Just such a healthy person is in room 306. He is in the hospital for routine tests. Having seen his test results, you realize that he has the right tissue compatibility. If you do nothing, he will survive without incident; the other patients will die, however. The other five patients can be saved only if the patient in 306 is cut up and his organs distributed. In that case, there would be one dead and five saved (1977, 3).

What is to be done? To be sure, the autonomy of everyone involved here has not been considered, and so we might think that the option of cutting up the one is off the table. But suppose it is considered, and we learn that the one has no problem with dying, and the five could care less about where the organs come from. What is the problem with cutting him up? Or suppose the five are the pitiless sort; they think the one should be cut up for their sake regardless of what the one wants. Why should the one's will to live be respected more than the wills of the five to live? Each of their desires to continue living can be just as strong if not stronger than the one's. Perhaps, however, the patient in Room 306 should not be killed, because it would be unfair to him; after all, he just happened to show up for a routine visit. Perhaps, then, we should adopt John Harris' proposal of a "survival lottery" in which sufficiently healthy people are selected at random to be killed and have their organs redistributed to the sick (1975). More human life would be saved if we did this. Complying with an exceptionalness norm against killing in organ donation, which presumably is in place to safeguard human life, actually results in greater loss of life. Therefore, it is irrational. Instead, we ought to overcome our squeamishness and be willing to approve of mortal harvesting, even if the victim is innocent, healthy and unwilling, so as to minimize the loss of multiple beings of such great worth. A truly equal consideration of these things makes this a morally serious position.

Nonetheless, this position is not taken seriously. Only the most committed consequentialists seriously entertain and debate the merits of such proposals (Tännsjö 2015, chap. 9). The majority of transplant ethicists are loath to embrace the tough-minded conclusions of such consequentialist reasoning (e.g. Veatch and Ross 2015, 209). No one writing in the DDR-related literature today would endorse the decision to kill the patient in Room 306 even under circumstances in which no nasty side-effects would result. An anti-consequentialist commitment to *the ethics of respect for patient autonomy* weighs considerably in the minds of many. Yet, as we have seen, this commitment is regularly qualified so as to only empower the sick to choose death by transplant surgery. To kill a healthy donor for her organs would harm her, and so we do not honor her wishes. To do such a thing, it is thought, would produce a bad outcome for the donor (the loss of "worthwhile" life); hence, the *ethics against doing harm* weigh considerably in the minds of many. Yet what about those who are in need of healthy organs? The *ethics of contributing to the welfare of others* motivates us to find efficient solutions to the problem of the organ shortage, and *the ethics of justice* constrain us to do so fairly. Ethicists who take all four of these ethical commitments seriously try to strike a balance between them, which somewhat predictably appeals to the ethics of informed consent to permit the sick to autonomously choose death by transplant surgery so as to benefit those who need healthy organs. Yet what should we make of this "balancing" act? Why should we seek to do it?

5.2 Principlism's balancing act

Before answering this question, we should examine in more detail the moral reasoning that motivates the need to balance these four commitments. Obviously, the four

commitments I referenced are constitutive of the reigning paradigm of biomedical ethics called "principlism," a moral framework developed most comprehensively by Beauchamp and Childress (2013). Part of what is attractive about principlism is that it purportedly condenses "morality to its central elements" (Beauchamp 1995, 181) and does not require commitment to any single comprehensive moral theory (like Kant's, Sidgwick's, or Aristotle's). The central elements of our 'common morality' they identify are beneficence, nonmaleficence, justice, and respect for autonomy. These are meant to provide a framework for ethical decision-making in circumstances that require action. They are not to be understood as axioms from which one can deduce any hard and fast rule of conduct. Rather, one is to specify the principles as much as possible and balance them against one another in any given case. In one case, we may have reason to respect autonomy over the pursuit of beneficial effects (people don't have to get flu shots); in another, we may have more reason to avoid harm rather than respect autonomy (we should disclose relevant information to an HIV patient's partner against the HIV patient's expressed wishes). No principle occupies a privileged place above the others; each of them only has a prima facie weight that always gives us a reason to consider them when deciding what to do. Taking their cues from W.D. Ross (1930), who distinguished between *prima facie* and *actual* duties, Beauchamp and Childress believe their framework helps agents "determine their *actual* obligations in such situations by examining the respective weights of the competing prima facie obligations (the relative weights of all competing prima facie norms)" (Beauchamp and Childress 2001, 14–15). Norms of justice and respect, then, only count so much — they do not absolutely constrain the decision-maker. Yes, one must consider them in a decision about what to

do, but if the circumstances are such that great harm would come by honoring them, they can be appropriately discharged, or "balanced off" by considerations of beneficence or nonmaleficence.[129]

5.2.1 Principlism is a species of consequentialism

While it is not presented as being committed to any comprehensive ethical theory, there are some good reasons to think principlism is a species of consequentialism, albeit one that gives regard to "principles" rather than rules. This is bound to be surprising. We have already noted principlism's indebtedness to Ross, and it is a common belief that Ross was an anti-consequentialist. Why, then, should we think that principlism is a species of consequentialism? By "consequentialism" I do not mean the standard view that *only* the consequences of our action matter in determining the rightness or wrongness of the action. Rather, I have in mind Anscombe's idea that there are no identifiable types of action that are automatically excluded from our practical reasoning "simply in virtue of their description," and "regardless of any further consequences" they might produce (1958, 10). In this sense, Ross is very much a consequentialist, since he would permit any action, no matter how offensive to rightness it is in itself, provided that the consequences of not performing it were bad enough. Although this is at odds with the standard view of Ross being an anti-consequentialist, because of his distinction between good and right

[129] Principlism need not be committed to the problematic view that disrespecting people's autonomy is sometimes justified; rather, the principlist can coherently hold that an appropriate measure of respect has been given by considering the importance of patient autonomy in ethical deliberation. It's worth noting, however, that Beauchamp and Childress do speak of "infringements" on the principle of respect for autonomy and that such infringements are sometimes justified (Beauchamp and Childress 2013, 22–23, 108). It would seem that, by this language, they would allow for "justified acts of disrespect." If this is the case, then this just counts against the intelligibility of their position for the reasons I gave at the beginning of this chapter.

actions, the standard view is superficial because it fails to recognize that even the right actions Ross lists — actions of fidelity, reparation, gratitude, justice, beneficence, nonmaleficence, and self-improvement — can be construed as being constitutive of the overall Good, and therefore treated as possible objects of maximization (Diamond, 1997). If this were not the case, then his ingenuous argument that there cannot be two worlds of equal value, which contain the same amount of welfare but not the same amount of virtue, would be unintelligible (Ross 1930, chap. 6). Ross is interested in broadening our scope of what is intrinsically good, not in specifying inviolable constraints on our actions. This should be no surprise since Ross explicitly denies any form of absolutism. Hence, Anscombe's punchy, but accurate comment about Ross and those like him whom she calls "Oxford Objectivists," who in her words,

> of course distinguish between 'consequences' and 'intrinsic values' and so produce a misleading appearance of not being 'consequentialists.' But they do not hold — and Ross explicitly denies — that the gravity of, e.g., procuring the condemnation of the innocent is such that it cannot be outweighed by, e.g., national interest. Hence their distinction is of no importance" (Anscombe 1958, 9n1).

In these respects, principlism is no different from "Oxford Objectivism," and therefore can be legitimately classified as a form consequentialism.

For the principlist as much as the Rossian, the goal of engaging in a balancing act between competing principles is to produce the best overall balance between prima facie rightness over prima facie wrongness. This is evident in Beauchamp and Childress' six conditions that "constrain" our balancing judgments:

1. Good reasons can be offered to act on the overriding norm rather than the infringed norm.
2. The moral objective justifying the infringement has a realistic prospect of achievement.

3. No morally preferable alternative actions are available.
4. The lowest level of infringement, commensurate with achieving the primary goal of the action, has been selected.
5. All negative effects of the infringement have been minimized.
6. All affected parties have been treated impartially (2013, 23).

As others have noted, none of these can be used to *justify* a balancing judgment; rather, as Tomlinson puts it, "they are criteria for comparing courses of action with respect to selecting the one which entails the least infringement of norms, without regard to which norm is the weightier" (1998). What makes for a "good reason" for the purposes of "outweighing" a competing principle is left unspecified and remains a matter of unprincipled moral judgment. In any event, we are to act so as to produce states of affairs in which there is more overall rightness rather than wrongness in the world.

Much of the criticism of principlism follows the criticism of Ross' theory in that it seems to be merely a matter of personal preference that decides which principle, in a given circumstance, outweighs the others (e.g. Davis 1995). While I think this is a salient criticism, there is a deeper one that further exposes its consequentialist character. Either principlism's notion of respect is unintelligible (there are justified acts of disrespect) or it comes cheaply (all we have to do is give due consideration). The reasons for why it may be unintelligible have already been given. The reasons for why it may come cheaply is that giving due consideration does not require any specifiable action beyond giving due consideration. This is clearly evident within act-utilitarianism. Returning to our patient in Room 306 with the assumption that cutting up the patient will produce the best overall consequences, the utilitarian transplant team could honestly say to the patient,

> Rest assured, you and your worth have been counted. Unfortunately, the scales do not tip not in your favor. Though we wish it weren't so and it is not your fault, we must secure your death for the greater good. Despite how you may feel, you must believe that you have been respected and that killing you does you no disrespect — after all, we have taken the value of your life and your interests into account.

Such claims simply ring hallow. The reason why is that the utilitarian transplant team does not properly recognize the patient's dignity for what it is, something that is incalculable. Rather, it is just counted as one good among others that can, in principle, be impartially considered within a calculus that takes everything into account for the sake of producing the best overall state of affairs. The same is true in principlism. While the principlist would forbid cutting up the patient in Room 306 to secure an additional drop of welfare, he would nevertheless recommend cutting him up so as to avoid what Nozick calls a "catastrophic moral horror" (1974, 30n). The fact remains that both moral frameworks treat human worth as a calculable good that can be weighed and found wanting in the face of competing goods. If this were not the case, then giving due consideration would not be sufficient for showing respect. We would have to do more such as refusing to calculate goods that have an "incalculable" worth. To "weigh" such things would not only be conceptually mistaken, it would also fail to treat them in accordance with their worth. In other words, it would be to disrespect them. A discussion of the moral status of the object of respect, then, is unavoidable, and I have already given my reasons in the previous chapter for thinking that every human being, no matter their condition of disability or development, has an ineliminable dignity. What is meant by this is that our worth is incalculable and that weighing our lives in some utilitarian calculus or Rossian balancing act against other desirable goods is simply not an option.

5.2.2 Against consequentialism

Before we leave this topic and move to our exploration of the options that could ground moral absolutes, we would do well to revisit some of the reasons why we should reject consequentialism as a moral theory in the first place. A salient criticism of the standard view of consequentialism is that it assumes every human action is, by itself, morally neutral and cannot be evaluated independently from the consequences it produces. But it is hard to believe that an action like rape could be morally neutral in this sense. We need not check the results of an act of sexual violence perpetrated on the victim without the victim's consent to know if it is morally wrong (Shafer-Landau 2015, 148–49). That the victim must be conscious (at some point) to experience the harm or whether other people will find out about the rapist's behavior is beside the point. It is just obvious that a stranger who has sex with a woman in a coma unbeknownst to her or anyone else does something seriously wrong.[130] So much the worse for act-consequentialism, then; human actions can have a moral character all on their own.

What about Rossian-style principlism? On this view, at least some of our actions are not morally neutral in and of themselves. Indeed, there is a set of intrinsically right

[130] The typical response from consequentialists is to attack this sort of claim as being grounded in mere "intuition" and that our cognitive ability to track moral truth has been shown to be unreliable given a number of psychological studies that have shown how our judgments are influenced by epistemically suspect heuristics and biases. Whatever the merits of this claim (see Berker 2009 for a critical response), the upshot is that we need a sound epistemic method to track moral truth (moderate versions of this claim make room for a "reflective equilibrium" between our methods and judgments). Yet how does one go about deciding which method is best apart from making judgments about the quality of its fundamental principles? Is there a further method one can appeal to show that it is never wrong to maximize the good? If so, why should *that* method be trusted? Indeed, an infinite regress threatens. Generally, the problem (as noted by Chisholm 1973) is that "methodism" falls on the horns of a dilemma: either the methodist claims to know her method is the right one or not. If not, then the adoption of some method, M, is arbitrary. If she claims to know, then she makes a judgment about M apart from M. To deploy M to claim M does not get us very far and is unacceptably circular. Assuming that moral skepticism is unacceptable, the consequentialist is in the same boat as the "intuitionist" when it comes to the status of our moral epistemology.

actions we always have a reason to perform, and we have a *decisive* reason perform one of them if and only if that action will produce the best balance of prima facie rightness over prima facie wrongness. Nonetheless, this view assumes, like every other form of consequentialism, that moral impartiality is just a function of accurately ranking the impersonal value of possible outcomes — value from "the point of view of the universe" as Sidgwick would say (1981 [1903]). But consider the normativity of things like justice and respect for autonomy, which are constitutive of principlism. Though they are impartial, they are not impersonal as they are just what we invoke so as to limit the efforts of others to produce the best overall consequences. Indeed, the normative function of justice and respect for autonomy as being *constraints* on our action cannot be derived from consequentialism. The only kind of normative function justice and respect for autonomy can have within consequentialism is that of being *conditions* on our action, provided that it is true that satisfying them tends to produce the best outcomes from an impersonal standpoint.[131] This standpoint is inadequate for making sense of our moral experience of these norms, because it leaves out an indispensable characteristic of both. Justice and respect for autonomy are "inter-personal" and yield what Paul Hurely calls an "interpersonal conception of impartiality" whereby we recognize "the equal moral significance that each person has independent of whatever moral significance she has from the impersonal standpoint" (Hurley 2009, 169). What other than human dignity could ground this moral significance we share equally with one another and independent from the value of the states of affairs we inhabit at a given moment? Indeed, it is hard to

[131] I borrow the condition/constrain distinction from Nozick (Nozick 1974, 28–29)

make sense of the moral significance of justice and respect for autonomy without the preeminent basis of human dignity. Yet in the reigning paradigm of biomedical ethics, this preeminence has to be rejected or downplayed so that justice and respect for autonomy can be balanced against concerns of beneficence and nonmaleficence. Under the influence of this kind of thinking, bans on euthanasia, destructive embryonic stem cell research, or mortal harvesting practices are sometimes thought to be problematic *just because* they conflict with the goals of healing, relieving suffering, and advancing scientific research.[132] As Gilbert Meilander wryly observes, it is as if bioethicists are surprised to learn that such bans conflict with these goals; he sardonically reminds us that the point of the bans is prohibit unacceptable ways to achieve them (2001, 9). To be sure, we should not beg the question against these practices; but neither should we assume they are acceptable or that we could make them acceptable just because they would achieve beneficial goals. To do so betrays a consequentialist mindset, which cannot adequately account for our widely accepted norms of justice and respect.

The reason why norms of justice and respect are not adequately accounted for in consequentialism is that they cannot do the work we want them to do when we assert them. They can only give us a 'boost' in our claim against others so that others have to consider them to some degree, but they do not give us a "trump," as Dworkin (1984)

[132] For example, Miller and Truog are bemused by the belief that it is acceptable to relieve suffering with strong palliative care medicine at the risk of hastening death, but unacceptable to administer euthanasia for the same reason (2012, 28). President Clinton's National Bioethics Advisory stated that the ban on embryonic stem cell research "conflicts with several of the ethical goals of medicine, especially healing, prevention, and research—goals that are rightly characterized by the principles of beneficence and nonmaleficence, jointly encouraging the pursuit of each social benefit and avoiding or ameliorating potential harm" (1999, 1:69). Sade and Boan complain that "By observing the DDR, substantial numbers of organs have been lost to transplantation" (2014, 21). As a general matter, Beauchamp cannot accept absolute rules, because they paralyze "our capacity to promote the common good by more collective public polices…" (1995, 185). It is as if absolutists are supposed to be scandalized by these claims.

would say, over whatever counter-claims others might marshal against them. Although this feature provides moral flexibility in place of rigidity, and thereby makes consequentialism attractive to some, it is also what makes its conceptions of justice so inadequately thin. Take rights-talk, for example. "Rights," says Wolterstorff, "are introduced into our practical reasoning when we go beyond taking the relative worth of life-states and life-events into account and bring the worth of human beings and social entities into consideration" (2008, 304). The primary reason we assert them is to prohibit others from bringing states and events into our lives that do not befit our worth. The significance of rights would be greatly diminished if they merely "gave our opponents a reason" not to bring those states and events into our lives, but did not outright require them not to do so. What they are supposed to do when we invoke them is *automatically* override whatever reason our opponents have for bringing those states and events into our lives. We can reasonably do this only if the worth of human beings *always* overrides the worth of states of affairs we might want to bring about. Only if it is the case that, as Wolterstorff says, "A fundamental feature of how the human-being system interacts with the life-goods system is that former always trumps the latter" (2008, 305). Those who deny this will find Dostoevsky's question, quoted in the epigraph, agonizing (2004, 227). Those who affirm this will find it easy to answer and any thought to the contrary repugnant; such an act would gravely wrong the child.[133] What is the best reason to believe that the human being system always trumps the life-good system? The answer has already been given: human beings have a worth (or dignity) that is incalculable.

[133] What is interesting about Dostoevsky's question is that he grants that Utopia is at stake; but on the form of consequentialism he has in view, torturing the child is no less required if a mere drop of the total overall welfare is at stake.

We should pause for a moment to reflect on just what is meant by "incalculable" here. To ascribe incalculable worth to human beings is not to necessarily ascribe "infinite value" to them or a worth that cannot be counted as it is sometimes assumed.[134] Indeed, the whole category of "value" may be inadequate to express what is meant by the notion of incalculability: that the human person is of such a worth (or status) that she is "not able to be calculated," not that it is "too great to be calculated." Calculability in this context is a metaphor for describing a finite amount of worth that can be factored into a calculation which will determine whether one can be treated as a mere means to some end or not. To have an incalculable worth in the relevant sense is to be inadmissible to such a calculation. This is part of what of what it means to be an end, not merely a means to an end. Our talk of "value" often misleads us to think that our worth is (finitely) additive (Stith 2004).[135] If our worth is merely additive, then we can be offset by whatever states of affairs are judged to have more worth, and we can be instrumentalized for the sake of obtaining them. This "additive fallacy" (to borrow the phrase from Kagan 1988 who uses it in a different way) is most clearly revealed in the writings of those who think that the wrongness of infanticide entails the wrongness of contraception, and therefore, so the

[134] For example, Young's (National Bioethics Advisory Commission 1999, 1:69) reading of Dyck (2002, chap. 4) conflates Dyck's idea of incalculability with infinitude.

[135] Stith aptly points out that if anyone really thought that innocent human life had an infinite value, then their attitude towards the proposal to kill 50 people to save one would be no different from their attitude towards the proposal to kill one to save fifty (2004, 172). The reason we care about not killing the 50 to save the one, is that each of the 50 has a trumping-right against being killed as a means to saving the one, *just as* the one has a trumping-right not to be killed as a means to saving the 50. Whether adding up the number of trumping-rights changes the respect-disrespect import of our actions is controversial. Wolterstorff thinks that if we were to be responsible for torturing three people, and had to choose between torturing one as opposed to two, we could torture the one without committing an act of disrespect (2008, 303). But it is at least paradoxical if not self-contradictory to do precisely what the right against torture rules out in order to honor it. It would seem that if one *must* disrespect someone, one must minimize the number people one disrespects if one can. This is not to say that disrespect is "justifiable" however; it is only to say that it is something we should minimize if he must do it.

argument goes, if the former is to be ruled out, then so should the latter — which, of course, is taken to be absurd (e.g. Glover 1977, 162–63; Tooley 1983). The argument goes like this: since in either case there is one less valuable person than there might have been, there is no measurable difference in value between placing an obstacle between sperm and egg and killing a newborn (side-effects notwithstanding).[136] Yet without presuming that contraception is licit, this argument just falsely assumes that human beings have an additive value rather than a worth that is incalculable. It is as if there could be no alternative to this view, and that it is somehow impossible to coherently believe that we have a worth independent of the impersonal states of affairs in which we inhabit, a worth that generates a norm of respect that entails we are not to be treated as some fungible good that can be weighed against other competing goods. The reticence we may feel about bringing more children into the world, and our deeply held belief that they should be protected and cared for if they happen to come along is not a fundamentally incoherent state of mind. Nor is a parent's grief, which may sense the loss of a child as being an *irreplaceable* loss. Indeed, these are attitudes that any good axiological theory should be able to explain, and not simply reject as confused. The problem with the additive view is twofold: (1) it wrongly assumes the moral significance of impartiality is impersonal rather than inter-personal, and (2) it wrongly attributes a quantifiable (non-

[136] "Valuable person" here can be taken in whatever way is preferred. The Glover citation is worth quoting in full as it succinctly puts the additive fallacy on display:

> The argument that it is wrong to destroy worthwhile life holds in most cases, although not always, and in some extreme cases the predictable quality of someone's life works as an argument the other way. But even where the worthwhile life argument does hold, it is no stronger against infanticide than not against conceiving a child. In either case, there is one less person with a worthwhile life. And, considering this reason in isolation, babies are replaceable (Ibid. 162–63).

The argument is valid but unsound, because it falsely assumes that our worth is wholly determined by the states of affairs of which we are constituents, i.e. whether or not a "worthwhile life" attaches to us.

zero) value to human beings, which makes them possible objects of maximization. These faulty assumptions entail a symmetry principle that produces absurd results: it is not the case that taking a human's life, considered all by itself, is morally on par with not creating one any more than breaking a promise, considered all by itself, is on par with not making one (Kaczor 2011, 26). What is common to both promises and human beings is that they are to be respected in their own right; violating them is simply to be avoided.

5.3 Options for grounding the Absolutist's Answer

As I have argued, having a rational nature endows one with a special dignity that is incompatible with being instrumentalized to such an extent that one should be destroyed for the sake of retrieving healthy organs. To do so would violate that dignity even if the donor consents. I also argued that Kant's morality could not be used to justify mortal harvesting without begging the question as to whether the incapacitated individual at the end of life retains this dignity. It would seem, then, that Kant's normative system of ethics is a good candidate for grounding the Absolutists Answer. "Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only," he says (Kant 1990 [1785], 46). To be an end in the Kantian sense is to be an object of respect, to be something that the practical reason of others should always recognize as requiring treatment that accords with its worth for its own sake. "In the realm of ends," Kant writes, "everything either has a *price* or a *dignity*. Whatever has a price can be replaced by something else as equivalent; on the other hand whatever is above all price and therefore admits no equivalent, has dignity" (Ibid., 51). Certainly, Kant's system is the obvious choice for my project is it not?

Well, yes and no. As enduring as his 'humanity formula' is, what is less enduring is Kant's belief that it could derived from his 'universal law' formula, and that the basis of our dignity is only a practical value internal to the exercise of (an idealized) rational agency, not an objective worth exemplified by actual rational animals themselves. I also share Anscombe's criticism of his idea that we legislate the moral law for ourselves, all by ourselves, without recognizing that the concept of legislation requires that the legislator be of a superior power. There is also the problem of relevant description. Anscombe correctly observes that Kant is unable to usefully apply his 'universal law' formula, especially in his ethics against lying, since one could adhere to a maxim to lie in such-and-such circumstances without creating any problem for the achievement of one's goals if everyone else were to adopt that maxim (1958, 2).

With these complaints noted, a contemporary Kantian could follow the work of Alan Donagan outlined in his *The Theory of Morality* (1977), which rejects Kant's universal law formula and restates Kant's humanity formula as "*It is impermissible not to respect every human being, oneself or any other, as a rational creature*" (Ibid., 66 emphasis original). This makes room for what Donagan calls a "twofold teleology in human action," one that directs us to form a rational life plan for the sake of producing a good and happy human life, and one that directs us to act for sake of others as ends-in-themselves (Ibid. 229). This second type of teleology is the teleology of respect. Once we know that a description of an action is incompatible with this form of respect in all cases, we know by way of deduction that that action is always impermissible. Of course, there can be disagreement over whether compatibility is achievable, but that is a debate that

absolutists can have amongst themselves about which prohibitions really are absolute.[137] In the face of a non-absolutist critic, there may or not be a heavy burden of proof on the absolutist to show why a given action or a practice is incompatible with respect for rational creatures. Lethally experimenting on human subjects against their will is obviously always incompatible with the respect we owe to them as rational creatures. Killing medically 'hopeless' donors for their organs with their consent is not obviously always incompatible with this respect. Hence, my goal in the previous chapter was to give the reasons why it is always incompatible: such a practice always places more value on the organs than the one who has them. In any event, the formal process of arriving at the Absolutist's Answer is as straightforward as rehearsing an argument in the form of *modus ponens*. The difficulty is found in giving a non-evaluative description of an action in the minor premise that is always incompatible with the relevant norm of respect in the major premise.[138]

While Donagan's project is both interesting and attractive (and the one I am inclined to agree with), the absolutist need not assume that morality stands wholly independent from 'the good' and must be wholly described in terms of 'the right.' Those who see a strong connection between our capacity for rational action and our capacity for human flourishing will find it hard to believe that the imperatives of morality could only

[137] For his part, Donagan thinks that, on the one hand, some acts of suicide are compatible with this form of respect; on the other, he thinks that every act that impairs one's health is incompatible (Ibid. 76). I leave it to the reader to decide if he could make room for lethal transplant surgery.

[138] Placing an evaluative description of an action in the minor premise results in a tautology. For example, we should not define murder as unjustified killing, because that would yield a conclusion that unjustified killing is impermissible, which is something we already know. Defining murder as the intentional killing of the innocent is meant to describe the action without loading an evaluative term into the definition. We can then derive a substantive conclusion that murder is impermissible, and if this holds in every case, then murder is always wrong.

be "categorical" and never "hypothetical" — to use Kant's terminology — quite the opposite, in fact (Foot 1972). Nonetheless, the Absolutist's Answer can be defended in a system of "hypotheticals" as the (New) Natural Law theory effectively demonstrates. Every view that goes by this name begins with the First Principle of Practical Reason, which, in Aquinas' words, says, "good is to be done and pursued, and evil is to be avoided" (I-II, q. 94, a. 2). From there one could analyze what it means to satisfy the First Principle in terms of a pre-moral action theory, which stipulates that no action is a *human action* unless it is aimed at some good or intends to avoid some evil (Grisez 1965). Even wrong actions, which are after all human actions, are all done under the guise of the good, or in pursuit of what seems good. What is good is an objective rather than subjective matter; there are goods that are desirable quite apart from whether they are desired or not. When one considers the various ways one can live well and flourish as a human being, one recognizes there is a plurality of fundamental or "basic goods" that are both constitutive of human flourishing and worth pursuing for their own sake. Such goods include things like life itself, friendship, health, knowledge, aesthetic experience, and play.[139] Yet there is no highest good; all the basic goods are incommensurable with one another in terms of their "rational desirability" (Boyle 2009, 81; cf. Finnis, Boyle, and Grisez 1987, 254–60). To do evil, then, is to intentionally damage these goods, in your own person or in that of another. In light of our knowledge about basic goods, it is strictly incompatible with morality to intend the death of a human being, as it would intentionally damage the good of human life, which is characterized by a dignity rooted

[139] The formal list of basic goods varies from thinker to thinker, but all of them include the good of life.

in its fundamental capacities for rational action (Lee and George 2008b). As Lee and George say, "To choose to destroy one instance of a basic good for the sake of other instances of goods is to adopt the attitude that human goods, including human lives, are only conditionally [not intrinsically] good" (Lee and George 2008a, 156). What about intending the death of someone convicted of a capital crime or who is unjustly attacking the innocent? One must never do it. The end of self-defense must come by way of means that only intend to "stop the attacker" and which would only accept the attacker's death as only foreseen side-effect of one's action in a fair and proportionate way; capital punishment ought to be avoided (Grisez 1970). As controversial as these outcomes may be, this version of Natural Law theory adequately grounds the Absolutist's Answer in that neither the surgeons nor the donor may ever intend the donor's death.[140] In either case, and therefore every case, the manner in which mortal harvesting is pursued fails to uphold an upright will towards the good.

A final option that could ground the Absolutist's Answer comes from traditional medical ethics itself, which is perhaps best articulated by the late Edmund Pellegrino (2005). While he too begins with the First Principle of Practical Reason, he argues that the fundamental good medical professionals are to safeguard and pursue is the good of healing, or as he puts it, "healing particularized in this patient here and now" (Ibid., 474). Particularizing the practice of healing in this way honors the fact that the patient is suffering, vulnerable, and in need of help. Embedded in the doctor's intention to help the

[140] Traditional Natural Law theorists deny that the First Principle is "pre-moral" and hold that there is a highest good (e.g. the Beatific Vision). Nonetheless, they too would rule out mortal harvesting as murder (i.e. the intentional killing of the innocent), and further claim that the mortal harvesters are not *using* practical reasoning (i.e. satisfying the First Principle), but are rather *abusing* it (Jensen 2015, 182).

patient is a "covenantal promise" to use the tools of the healing art in the best interests of the patient — not in the best interests of third parties like those who need the patient's organs. As such, the healing art is one aimed at safeguarding and promoting the patient's health, that is, "the well functioning [*sic*] of the human organism, body, mind, and soul, to the degree possible" (Ibid., 475). Consequently, physicians must never kill; "Nothing is more contrary than killing to the ends of medicine as a healing art," Pellegrino says (Ibid.). Medicine is transformed into something else if killing is allowed, perhaps some sort of humanitarian practice concerned with safeguarding and promoting "quality of life" concerns, but not one that is primarily concerned with healing. What matters more than the particular patient before us in euthanasia and assisted-suicide practices is the patient's suffering, because it is assumed that this suffering can only be relieved by eliminating the patient himself. Organ donation euthanasia practices, of course, are not only concerned with the suffering of the patient before us, but also the suffering of others who need the patient's organs. In either case, obtaining or avoiding certain states of affairs is more important than destroying the human being before us. This is morally problematic because human beings have, according to Pellegrino, an "inherent dignity" that is more fundamental than having an exercisable capacity for autonomous choice that might authorize its own destruction (Ibid., 478). Compromising this dignity in any way is simply out of the question for doctors, who are to treat the patient before them regardless of their race, sex, class, or degree of disability. The sad history of medical atrocities from Mengele's to those of Marion Sims is a history of compromising human dignity with the assumption that the worth of human life varies with its circumstances and accidents of birth. Part of avoiding evil, then, is to categorically reject any proposal that would allow

us to kill some patients for their organs (with their consent?) on the basis of their diminished health status.

In all three of these ways, then, whether it be through Kantian-style respect, Natural Law theory, or traditional medical ethics, the Absolutist's Answer is defensible. Their unifying theme is that human dignity is of primary importance in each, and cannot be acted against to secure some desirable state of affairs.

5.4 Can consequentialism support the Absolutist's Answer?

The forgoing arguments conclude that consequentialism of all stripes should be rejected. But many very smart philosophers are not as eager to do so as I am, and I suspect many bioethicists who are more or less committed to the framework of principlism would hesitate to embrace any one of the absolutist systems suggested here. There is also a serious argument that just about every moral theory can be "consequentialized" — that is, given a consequentialist interpretation (Portmore 2009) — due to the difficulty of denying the claim that right action should be constitutive of the overall goal of our action, and not merely a constraint on our action. All of this raises an important question: must the defender of the Absolutist's Answer be committed to the falsity of consequentialism? While I am inclined to think so, I am going to suppose I am wrong for the sake of argument, and put on the hat of a consequentialist in order to give an argument in favor of the claim that the DDR is "virtually absolute."[141] By this I do not

[141] One might object why I frame things this way, since it is possible for a "threshold" deontologist to deny the Absolutist's Answer too, and therefore putting on the hat of a consequentialist does nothing to illuminate the true nature of the problem. The main idea of threshold deontology is that one should not violate the rights of individuals even if it would produce bad outcomes, but only up to a point. When some number of lives are at stake, the rules against things like rape, torture, and murder can be set aside and we can do those things in order to save the relevant number of lives. The principle problem with this view is that it generates contradictions, as it assumes the norms of deontology (don't treat people as mere means)

mean that it *must not* be overridden by some other moral concern, but that, for good contingent reasons, it weighs so heavily that it *will not* be overridden by some other moral concern. Rules against rape are a paradigm example of this sort of "virtual absolute" that principlists are happy to embrace (Beauchamp and Childress 2013, 19), since it is very unlikely that some moral catastrophe would occur if rape were not permitted in some case.

Hence, my strategy will be to deploy some version of rule-consequentialism, and defend the claim that the rule against killing donors for their organs is in place because it is *optimific* — that is, it helps produce the best overall consequences.[142] If this is true, then consequentialism does not entail that the DDR can be relaxed or broken, because doing so would bring about less than optimal results. As is well known, there is some support for this idea in Mill with regard to rules of justice that preserve peace and security — "the very groundwork of our existence," as he puts it (1863, 80). Of these rules Mill says,

> They have also the peculiarity, that they are the main element in determining the whole of the social feelings of mankind. It is their observance which alone preserves peace among human beings: if obedience to them were not the rule, and disobedience the exception, every one [*sic*] would see in every one else a probable enemy, against whom he must be perpetually guarding himself. What is hardly less important, these are the precepts which mankind have the strongest and the most direct inducements for impressing upon one another (Mill 1863, 87–88).

---

and the norms of consequentialism (maximize the good) are commensurable and they are not. For example, if the threshold number is 100 lives, we can torture someone to save them, but if just one is released, we must stop torturing — 99 isn't enough to cross the threshold. This implies that, at least in some circumstances, it is permissible to torture one person to save a single life, which is contrary to the assumptions of threshold deontology (for further argument along these lines see Alexander 2000). In any event, I do not accept this objection, because threshold deontology, if it does not collapse into consequentialism all on its own (for details, see Alexander and Moore 2016; Sen 1982), is perhaps the easiest form of deontology to consequentialize.

[142] The gold-standard defense of this view of consequentialism can be found in Brad Hooker's book *Ideal Code, Real World: A Rule-Consequentialist Theory of Morality* (2000).

While Mill allows for the rules against interference with one's freedom to be abrogated to save a life, he is averse to the idea that we could take one's life to save another. Such an act would be contrary to the "social feelings of mankind" that are essential to our peaceful existence.[143] Mill's idea is an enduring one and even shows up in the writing of the late Harriet McBryde Johnson. While she was certainly no utilitarian, she was a practical thinker, as lawyers tend to be, and had this to say in her afterword regarding her justly famous debate with Peter Singer:

> Throughout history, certain categories of people have been excluded from the polity, often based on ideologies that define some human lives as worthless or not worth living, unduly burdensome or burdened, or otherwise problematic. Laws that address problems by killing problematic individuals subvert the social commitment to justice—giving each member what he or she needs, striving to hear all voices. As a matter of policy, I favor an irrebutable legal presumption that every human life is inherently and uniquely valuable. *I think this presumption is so useful toward building a just society that I just don't worry about whether it can be validated or is ultimately "true"* (McBryde Johnson 2009, 204 emphasis added).

This idea of "usefulness" regarding principles of dignity and equality is one that we can exploit for defending the Absolutist's Answer and by extension the DDR within a consequentialist framework.

In particular, for our purposes, the basic claim to be defended is that we should not allow, as a matter of public policy, someone to be killed for their organs because of the bad side-effects it would produce. Because organ transplant is performed on an

[143] It will be objected that rule-consequentialism is a non-starter due to J.J.C. Smart's "irrational rule worship" objection (Smart and Williams 1973, 10). If we *know* that violating the DDR will produce the best overall outcome for everyone involved, following the rule is irrational. Smart's criticism is penetrating, but it is open to the rule-consequentialist to reply that we are never in a position to know for sure that violating the rule will produce the best overall outcome, because (1) we lack detailed knowledge about an action's remote effects, (2) obtaining such information would overburden the decision-maker, (3) decision-makers are often biased and fallible. Avoiding the risk of being wrong explains why the rule should be accepted by society.

institutional basis, it must accord with a policy aimed at achieving the best results for everyone involved now and in the future. If the side-effects undermine the policy's intentions or harm other social goods (like justice) that are conducive to the overall Good, it ought to be rejected. The case of the "survival lottery" proposal illustrates this problem clearly. Harris imagines what some of the negative side-effects would be when he says, "Every post might bring a sentence of death, every sound in the night might be the sound of boots on the stairs," and that the procurement process would "prove distressing to all concerned" (1975, 84–85). Noting this difficulty, Harris thinks that our aversion to the proposal can be overcome by "only a long period of education or propaganda" (propaganda!). Nevertheless, he acknowledges what he takes to be an insurmountable difficulty: "The lottery scheme would be a powerful weapon in the hands of someone willing and able to misuse it" (Ibid., 87). Even if the problems of distress and abuse were surmountable, the proposal would still incentivize people to live unhealthy lives so that they would be excluded from the set of healthy organ sources (Singer 1977). Since this is contrary to the goal of maximizing the number of healthy people as possible, the argument for the survival lottery is self-defeating.

A similar strategy can be deployed against policies that require the donor to be killed through the mechanism of informed consent at the stage of life when the donor's death is "imminent" (Truog, Miller, and Halpern 2013, 1288). While revisionists acknowledge that some potential donors uphold values that preclude such an approach (Ibid., 1289), the negative effects this could have on donation rates is not taken as seriously as it should be. If Miller and Truog are right, and vital organ retrieval cannot standardly proceed without killing the donor, then vital organ donation is on the same

moral plane as voluntary euthanasia. While Miller and Truog would be happy to accept this as progress, many will not. Roman Catholic theology would have to change its endorsement of organ donation from a praiseworthy act of charity to a crime against humanity, which would have no small impact on a sizable portion of potential donors. The same would be true of many traditional Protestants, Jews, and Muslims. This is not to say that no one from these faith traditions would be willing to donate, but that their decision to do so would be morally burdened in a way it is not now. The same would be true for the majority of donors, who are only willing to donate vital organs after death. (DuBois and Anderson 2006).[144] Morally burdening if not excluding such large portions of the public from donating would be disastrous for donation rates.

Not only would the donors feel this moral burden, but so would the transplant teams themselves. Medical schools would have to teach transplant surgeons that they should be willing to kill their patients on the operating table, and accept responsibility for their deaths. Yet since no one has a duty to kill and medical professionals do not go into medicine to take life but rather to save it, there is a good chance that the transplant enterprise will most likely suffer a loss of competent professionals who are willing and able to facilitate organ transplants. Empirical support for this claim comes from a study, which found that agreement with the donation procedure "significantly decreased" among health professionals when they were pressed to consider procedures lethal to the patient

[144] To be sure, how death is defined is crucial in that there is some support for donating organs when one criteria for "higher-brain" death is satisfied. Be that as it may, DuBois and Anderson report, "69% agreed that they would only allow donation after the patient was taken off the ventilator and his or her heart stopped beating, which would require use of a DCD protocol and reduce the number of procurable organs" (Ibid., 69). In any event, the majority of potential donors are not willing to violate the dead donor rule, even if members of a substantial minority are (Siminoff, Burant, and Youngner 2004).

(Bastami et al. 2013, 902). Specifically, the authors report,

> Fewer than 5% of respondents answered strongly agree/agree to allow donation after cardiac death while also answering disagree/strongly disagree that the patient is definitely dead, suggesting little support to abandon the dead-donor rule" (Joffe, Anton, and deCaen 2008).

This is hardly ever considered in such proposals. Rather, worries about a public backlash and their unintended consequences on the medical profession are just dismissed as "facile" presumptions; whatever worries there may be can be remedied with "education" (Miller and Truog 2012a, 148). Presumably, this "education" is one in which we all collectively learn (without begging any questions) that (1) brain death does not entail death, (2) that there is no difference between killing and withdrawing life-support, and (3) that killing for organs is compatible with respecting persons and having professional integrity in the medical profession. Even if we generously assume the probability of "educating" members of our society to hold just one of these views is, say 0.75, the probability of someone being re-educated to hold all three views, which is necessary for the acceptability of their proposal, dwindles to 0.42. Miller and Truog's optimism in the re-education project is nothing short of astonishing.[145]

[145] It is also worth pointing out that Miller and Truog's requirement of informed consent dramatically changes our standard procedures, which is contrary to their assumptions. James DuBois (2011, 46) is worth quoting to see why:

> Complicating matters further, deceased organ donation is not currently predicated upon informed consent […]. It rather depends on the notion of gifting, which requires significantly less information and simpler processes. Informed consent requires providers to communicate to individual patients significant information about procedures, risks, benefits, and alternatives, and it requires individuals to understand, appreciate, and reason with the information prior to making a voluntary decision. Within the post-DDR era, we would need to scrap our current registries entirely and rebuild them slowly after completing a formal informed consent process with each individual or their proxies, because "formerly deceased" organ donation would now be a lethal form of living organ donation. […] In 2010, my local organ procurement organization (OPO) had a consent rate for deceased donation exceeding 80%.1 Good luck maintaining that, local donation coordinators!

Of course, not all revisionists have the same view of death as Miller and Truog do, and some are content to endorse death declarations on the basis of neurological criteria. They just want to expand the pool of potential donors to those who are imminently dying, or those who request the withdrawal of life-support. Yet it is not clear just how big of an expansion this would be. Some advocates of "organ donation euthanasia" admit that such a substantial policy change would have a "small impact upon the organ shortfall" and that this undermines the case for it "to some degree" (Wilkinson and Savulescu 2012, 47). Nevertheless, the significance of allowing this practice is not only related to lessening the organ shortfall, it is also about expanding the good of patient autonomy. What sort of negative consequence could follow from that?

The answer is that trust in the transplant enterprise may be harmed as well and perhaps the doctor-patient relationship in general. Why think that allowing a few people the choice to be killed on the operating table would erode public confidence in the transplant enterprise? What is the connection between trust and permitting doctors to kill for organs? James DuBois gives the standard answer when he writes:

> Some scenarios in which organ harvesting would begin before death sound fairly harmless to some: consent has been given, conscious life is not cut short, and death is imminent. However, such scenarios are not what most people are likely to imagine—*no matter how much they are educated*. Surveys already show that a significant portion of the population fears that, by agreeing to become organ donors, their health care will be compromised in an emergency situation. Images will arise of organs being harvested when one is critically injured and perhaps still within the realm of recovery. Moreover, the public and the medical community know that informed consent is tricky. Numerous studies show that advanced directives are not consistently understood or implemented as patients wish. Saying that organ harvesting will only proceed with consent simply does not amount to saying that harvesting will not happen unless the patient explicitly wants it to happen in a specific situation. Proxies and advanced directives may legally achieve ends that are not desired by patients (1999, 132 emphasis added).

The fear of compromising one's end-of-life care by virtue of identifying as a donor may not sound rational to revisionists or caring medical professionals, but it remains a fact that many people feel it. Better education will not change the fact that the patient, who will be languishing in the ICU and empowered to die by transplant surgery, will be in the hands of doctors, who will be laboring under pressure from hospital administrations, organ procurement organizations, and basic triage concerns. Under such circumstances, being able to trust one's doctor to value one's life and act in an unbiased manner with respect to all the available treatment options goes beyond what education can enable in a patient; it will take no small amount of courage to trust one's doctors in such circumstances, and there is no reason given as to why we should expect patients to rise to the occasion.

I, for one, think that there would be a reinforcement of something rational behind the fear of the transplant community, due to what I emphasized in the last chapter: patients at the end of life would be judged to have less worth than the rest of us by virtue of being empowered to give up their lives in organ donation euthanasia. It is rational to fear being judged by one's health care providers that one no longer has a life worth living, and thereby judged as a low priority for treatment. Add to that the background assumption that there are those in need of organs who are judged to still have a life worth living, and it is easy to understand why people would be afraid to identify themselves as donors: their fear would be borne out of a sense of social inequality based on how much "worthwhile" life one is perceived to have left. As is well-known, the experience with social inequality is correlated with fear of the transplant system. It has long been observed that African-Americans are less willing to donate than their white

counterparts.[146] Instead of working to alleviate those fears, we would compound them by giving underprivileged groups yet another reason to believe that their doctors would be less committed to their healthcare interests if it were known that they were registered organ donors. No one wants to be viewed primarily in terms of being a potential donor, rather than a patient.

Even advocates of voluntary euthanasia should be concerned as to whether "organ donation euthanasia" will have harmful effects on the primary aim of their practice, which is to secure the most comfortable death for the patient possible. Euthanasia via transplant surgery will require procedures and protocols that limit the time spent with loved ones in the final moments of life and perhaps the degree of comfort one is entitled to in the events leading up to death, since one must he prepped for surgery. In a normal case of voluntary euthanasia, the physician's efforts are concentrated on relieving suffering and causing the most comfortable death possible. Physicians who facilitate organ donation while performing an act of euthanasia cannot be solely committed to this,

---

[146] One study found that African-Americans were more likely than whites to agree with the claim "If doctors know I am an organ donor, they won't try to save my life," and would be more willing to donate if they knew their organs would go to other African-Americans (Siminoff, Burant, and Ibrahim 2006). That members of this community might fear that they would receive less than adequate end-of-life care so that a white person might benefit from one of their organs, is not an irrational one. As Siminoff, Burant, and Ibrahim explain:

> African Americans disproportionately have end-stage kidney disease, yet, they are less likely than whites to receive kidney transplantation. While 39% of people on the kidney waiting list are African American, only 23.0% of deceased donor organ recipients are African American. African Americans needing a kidney transplant wait, on average, 1,335 days, compared with 734 days for whites (Ibid., 995).

Also note the following report from an African-American survey respondent to get a better sense of how this fear manifests:

> [Y]ou heard this rumor that especially with the younger, 16- or 18-year-olds, bodies were still in healthy prime but they got shot up, shot to death. And there was that nasty rumor going around that they were purposely letting young boys die so that they could recover the heart, the lungs, the kidneys, because these were basically healthy children who hadn't had another disease. And there was a rumor that the health care workers were checking the box on the back of their driver's license (DuBois et al. 2009, 2396-7).

however; they must also consider the interests of third-parties in attaining the healthiest organs for transplant possible, and therefore must act upon the patient's body for the sake of the wellbeing of the organs, and not only for the sake of the wellbeing of the patient. Adequate anesthesia may secure an acceptable degree of comfort, but the promise of it cannot change the fact that one must spend one's final moments in the company of masked strangers rather than with one's family and friends. While these drawbacks may be outweighed by the "psychic benefit" of donating, they nonetheless remain drawbacks that have to be overcome. In any event, the conflict of interest between providing the most comfortable death possible and harvesting the healthiest organs possible is enough to unsettle any potential donor's mind. There is already concern that requests for consent to donate *after* euthanasia in Belgium "cause a breach of trust with the treating physician" because the patient "might get the impression that the physician is only willing to perform euthanasia *because* the patient will donate organs" (Bollen et al. 2016, 488 emphasis original). While this *may not* be the case for the Belgian euthanizer, it *has* to be the case for transplant-euthanizer, because his professional role requires him to be willing to perform an act of euthanasia *only if* the patient is willing to donate organs. All the rarified talk about promoting self-determination and patient autonomy through organ donation conceals a clear and compelling social pressure to get on with the business with dying so healthy organs can be extracted for those who are deemed worthier of them. This should not be what advocates of voluntary euthanasia should want if they care about euthanasia being truly *voluntary*.

Finally, while revisionists are optimistic that their policies will be made acceptable to the public through an honest and forthright informed consent process, they

tend to ignore how easily the public can be manipulated by propagandists in opposition to their cause (DuBois 2011, 46). If someone like Sarah Palin was able to deeply harm public trust in President Obama's health care legislation by falsely claiming that it would create bureaucratic "death panels" (Gonyea 2017), how much more will the transplant enterprise be harmed by (fake?) media outlets that will seize upon the fact that transplant teams will literally kill you for your organs? To be sure, if the goal of our policy is to expand patient autonomy or to be more honest about killing in transplant surgery, then these considerations do not matter as much. But if our goal is to maximize the organ supply, the risk of creating such a controversy should give us pause.[147] Indeed, there is good reason to think the best way to do that is to respect the dignity of human persons by not killing them for their organs.

5.5 Conclusion

In this chapter, I have argued that norms of respect are ultimately shaped by the fundamental principles of conduct and the theories of value we assume, and that some of these are inadequate for making sense of our moral experience of justice, respect for autonomy, and respect for the dignity of the human person in its nascent and waning forms. In particular, I argued that merely giving due consideration to people and their interests is not sufficient for showing respect as certain consequentialist theories of morality would have us believe. One of these theories is W.D. Ross's which underlies the

[147] What is often ignored in the debate over the DDR is the dubious assumption that the only way to really increase the organ supply is to abandon the rule; yet there may be better ways of increasing the supply through less controversial means. For example, we could fund and construct more Intensive Care Units (ICUs). Because most donors die in the ICU, the more ICUs we have on hand, the more donors of vital organs there would be (Wilkinson & Wilkinson, 2011). This would have the beneficial effect of not offending large portions of the population who affirm that human life is inviolable.

moral framework of principlism, the reigning paradigm of today's biomedical ethics. Its commitment to non-absolutism would permit, under certain unusual circumstances, killing an innocent and unwilling person for their organs. To explain what is wrong with this outlook, I argued that it was a mistake to assume that the worth of the human person has an additive value that merely gives others a reason not to act against the person. Rather, the innocent human person has a worth that always outweighs whatever reason we might have for bringing about some desirable states of affairs, which entail the intentional destruction of the person. This worth accounts for our moral experience of justice in the form of rights that trump, not rights that merely give others a reason to consider them. The trumping import of rights is best explained by the fact that we have a certain dignity that is above all price, one that makes us the sort of thing that cannot be weighed and found wanting in some utilitarian calculous or Rossian balancing act.

While I did not commit myself to any one moral system that grounds the norm that we should never, under any circumstances intentionally destroy innocent subjects of dignity (what I called the Absolutist's Answer), I explored three options that could provide such grounds with a view to supporting an exceptionless interpretation of the DDR. We also saw that the Millian tradition of rule-consequentialism can support such an interpretation because it is able to prioritize norms of respect for human dignity on the basis that they are believed to produce the best for everyone involved. While I think this is less plausible on a theoretical level than the others views I surveyed, there are good practical reasons to think that abandoning the DDR rule would have negative effects on the overall goals of the transplant enterprise. Contrary to what John Harris says in the epigraph (1978, 100), we should be concerned with what rights people have, especially if

they include an inalienable right not to be killed, for such things constrain our answers with respect to the (sometimes insidious) question “What is to be done?”.

Conclusion

The goal of this dissertation has been to give a systematic justification of the DDR in transplant ethics. Along the way, we have surveyed the rule's history and development, how it is related to our ethics of killing, as well as the nature of the human being that is the object of our actions in medical practice. The argument I've advanced is a deductive one, which supports a morally absolute conclusion:

1. Transplant protocols that would have us secure the donor's death, would have us kill someone for their organs.
2. Killing someone for their organs disrespects the worth of someone, namely the one killed.
3. No act that disrespects the worth of someone is permissible.
4. Therefore, transplant protocols that would have us secure the donor's death are impermissible.

This conclusion may be taken to be identical with the DDR or the reason behind it if the rule is construed as an imperative statement like, "Do not cause death by transplant surgery" or "Organ recovery must not cause death."

Each premise of the argument has received significant attention to explain precisely what I mean by each term, while considering the objections that thoughtful critics might put forward. I do not for a moment think that I have satisfied the critics of the DDR or the traditional norms against killing the innocent in a medical context. However, my goal has not been to satisfy the critic, but to dispense with the complaints that no systematic effort to justify rule has been made or that it is philosophically indefensible.

The future of the DDR remains uncertain as medical professionals the world over are becoming less concerned about upholding the norm against doctors killing their patients for any reason. Support for this norm may continue to erode if it is the case that we cannot reliably determine if someone is brain-dead. The legal outcome of the unusual case of Jahi McMath (Aviv 2018), which at the present writing is under review in the courts, may show that our practices of declaring death on the basis of the currently accepted tests for total brain failure cannot be trusted. Nonetheless, further empirical research is needed to address the question of whether the transplant community would continue to operate in standard fashion if it were to be shown that our tests for brain death were unreliable. If it does, my hope is that the arguments given here will be taken seriously even if they are ultimately rejected. That is the best a philosopher can hope for, and it is the goal I have labored towards in developing and defending this argument. Yet if my arguments are judged to be sound, and if our current death declaration practices are totally unreliable, then we will need to have the moral courage to stand against our organ procurement practices as they are currently practiced. While this would no doubt be hard, it would be right thing to do.

Bibliography

Advisory Committee. 1994. *Report of the Human Embryo Research Panel*. National Institutes of Health.

Alexander, Larry. 2000. "Deontology at the Threshold." *San Diego Law Review* 37: 893.

Alexander, Larry, and Michael Moore. 2016. "Deontological Ethics." In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Winter 2016. Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/win2016/entries/ethics-deontological/.

Anscombe, G. E. M. 1958a. "On Brute Facts." *Analysis* 18 (3): 69–72. https://doi.org/10.2307/3326788.

———. 1958b. "Modern Moral Philosophy." *Philosophy* 33 (124): 1–19.

———. 2005. "Action, Intention, and 'Double Effect.'" In *Human Life, Action and Ethics: Essays by G.E.M. Anscombe*, edited by Mary Geach and Luke Gormally, 207–27. Exeter, UK ; Charlottesville, VA: Imprint Academic.

Arnold, Robert M., and Stuart J. Youngner. 1993. "The Dead Donor Rule: Should We Stretch It, Bend It, or Abandon It?" *Kennedy Institute of Ethics Journal* 3 (2): 263–78.

Austriaco, Nicanor. 2005. "On Reshaping Skulls and Unintelligible Intentions." *Nova Et Vetera* 3 (1): 81–100.

Aviv, Rachel. 2018. "What Does It Mean to Die?" *The New Yorker*, January 29, 2018. https://www.newyorker.com/magazine/2018/02/05/what-does-it-mean-to-die.

Baier, Kurt. 1979. "Technology and the Sanctity of Life." In *Ethics and Problems of the 21st Century*, edited by Kenneth E. Goodpaster and Kenneth M. Sayre, 160–74. South Bend: University of Notre Dame Press.

Bailey, Andrew M. 2016. "You Are an Animal." *Res Philosophica* 93 (1): 205–218.

Baker, Jeffrey C. 1968. "Liability and the Heart Transplant." *Houston Law Review* 6: 85.

Baker, Lynne Rudder. 2000. *Persons and Bodies: A Constitution View*. Cambridge; New York: Cambridge University Press.

———. 2008. "Response to Eric Olson." *Abstracta* 3 (3): 43–45.

Baker, Stuart G. 2014. "A Cancer Theory Kerfuffle Can Lead to New Lines of Research." *JNCI Journal of the National Cancer Institute* 107 (2). https://doi.org/10.1093/jnci/dju405.

Bard, Bernard, and Joseph Fletcher. 1968. "The Right to Die." *The Altantic Monthly* 221 (4): 59–64.

Barnes, Elizabeth. 2016. *The Minority Body: A Theory of Disability*. New York: Oxford University Press.

Barry, John M., and Joseph E. Murray. 2006. "The First Human Renal Transplants." *The Journal of Urology* 176 (3): 888–90. https://doi.org/10.1016/j.juro.2006.04.062.

Bastami, Sohaila, Oliver Matthes, Tanja Krones, and Nikola Biller-Andorno. 2013. "Systematic Review of Attitudes toward Donation after Cardiac Death among Healthcare Providers and the General Public." *Critical Care Medicine* 41 (3): 897–905. https://doi.org/10.1097/CCM.0b013e31827585fe.

Beauchamp, Tom L. 1995. "Principlism and Its Alleged Competitors." *Kennedy Institute of Ethics Journal* 5 (3): 181–198.

Beauchamp, Tom L, and James F Childress. 1979. *Principles of Biomedical Ethics*. 1st ed. New York: Oxford University Press.

———. 1983. *Principles of Biomedical Ethics*. 2nd ed. New York: Oxford University Press.

Beauchamp, Tom L., and James F. Childress. 2001. *Principles of Biomedical Ethics*. Fifth. New York: Oxford University Press.

———. 2013. *Principles of Biomedical Ethics*. Seventh. New York: Oxford University Press.

Beecher, Henry K., R. D. Adams, and A. Clifford Barger. 1968. "A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death." *JAMA* 205 (6): 337–40. https://doi.org/10.1001/jama.1968.03140320031009.

Beecher, Henry K., and Henry I. Dorr. 1971. "The New Definition of Death: Some Opposing Views." *International Journal of Clinical Pharmacology, Therapy & Toxicology* 5 (2): 120–24.

Belkin, Gary. 2014. *Death before Dying: History, Medicine, and Brain Death*. Oxford University Press.

Berker, Selim. 2009. "The Normative Insignificance of Neuroscience." *Philosophy and Public Affairs* 37 (4): 293–329.

Berman, Emile. 1968. "The Legal Problems of Organ Transplantation." *Villanova Law Review* 13 (4): 751.

Bernat, J. L. 2006. "Are Organ Donors after Cardiac Death Really Dead?" *Journal of Clinical Ethics* 17 (2): 122–32.

Bernat, J. L., C. M. Culver, and B. Gert. 1981. "On the Definition and Criterion of Death." *Annals of Internal Medicine* 94 (3): 389–94.

Bernat, James L. 1998. "A Defense of the Whole-Brain Concept of Death." *The Hastings Center Report* 28 (2): 14–23. https://doi.org/10.2307/3527567.

———. 2008. "The Boundaries of Organ Donation after Circulatory Death." *New England Journal of Medicine* 359 (7): 669–71. https://doi.org/10.1056/NEJMp0804161.

———. 2013. "Life or Death for the Dead-Donor Rule?" *New England Journal of Medicine* 369 (14): 1289–91. https://doi.org/10.1056/NEJMp1308078.

———. 2014. "Whither Brain Death?" *The American Journal of Bioethics* 14 (8): 3–8. https://doi.org/10.1080/15265161.2014.925153.

Bernat JL. 1996. "Physician-Assisted Suicide Should Not Be Legalized." *Archives of Neurology* 53 (11): 1183–84. https://doi.org/10.1001/archneur.1996.00550110135024.

Birch, Samuel C. M. 2013. "The Dead Donor Rule: A Defense." *Journal of Medicine and Philosophy* 38 (4): 426–40.

Bishop, J. P. 2006. “Euthanasia, Efficiency, and the Historical Distinction between Killing a Patient and Allowing a Patient to Die.” *Journal of Medical Ethics* 32 (4): 220–24. https://doi.org/10.1136/jme.2005.013839.

Bishop, Jeffrey Paul. 2011. *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*. Notre Dame Studies in Medical Ethics. South Bend: University of Notre Dame Press.

Blatti, Stephan. 2014. “Animalism.” In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Summer 2014. http://plato.stanford.edu/archives/sum2014/entries/animalism/.

Bollen, Jan, Rankie ten Hoopen, Dirk Ysebaert, Walther van Mook, and Ernst van Heurn. 2016. “Legal and Ethical Aspects of Organ Donation after Euthanasia in Belgium and the Netherlands.” *Journal of Medical Ethics*, March, medethics-2015-102898. https://doi.org/10.1136/medethics-2015-102898.

Boonin, David. 2002. *A Defense of Abortion*. Cambridge: Cambridge University Press.

Boorse, Christopher. 1977. “Health as a Theoretical Concept.” *Philosophy of Science* 44 (4): 542–73. https://doi.org/10.1086/288768.

Boucek, Mark M., Christine Mashburn, Susan M. Dunn, Rebecca Frizell, Leah Edwards, Biagio Pietra, and David Campbell. 2008. “Pediatric Heart Transplantation after Declaration of Cardiocirculatory Death.” *New England Journal of Medicine* 359 (7): 709–14. https://doi.org/10.1056/NEJMoa0800660.

Bouchard, Frédéric, and Philippe Huneman. 2013. *From Groups to Individuals: Evolution and Emerging Individuality*. Cambridge: MIT Press.

Boyle, Joseph. 2009. “Exceptionaless Rule Approaches.” In *A Companion to Bioethics*, edited by Helga Kuhse and Peter Singer, Second Edition, 77–84. Blackwell Companions to Philosophy. Malden: Wiley-Blackwell.

Boyle, Joseph M. 1977. “Double-Effect and a Certain Type of Embryotomy.” *Irish Theological Quarterly* 44 (4): 303–18. https://doi.org/10.1177/002114007704400404.

Braine, David. 1992. *The Human Person: Animal and Spirit*. South Bend, Ind: University of Notre Dame Press.

Bratman, Michael E. 1992. “Shared Cooperative Activity.” *The Philosophical Review* 101 (2): 327–41. https://doi.org/10.2307/2185537.

———. 2014. *Shared Agency: A Planning Theory of Acting Together*. Oxford University Press Usa.

———. 2015. “Précis of Shared Agency: A Planning Theory of Acting Together.” *Journal of Social Ontology* 1 (1): 1–5.

Brock, Dan W. 1992. “Voluntary Active Euthanasia.” *The Hastings Center Report* 22 (2): 10–22. https://doi.org/10.2307/3562560.

Brock, Stephen L. 1998. *Action and Conduct: Thomas Aquinas and the Theory of Action*. Edinburgh: T&T Clark.

Callahan, Daniel. 1993. *The Troubled Dream of Life: In Search of a Peaceful Death*. New York: Simon and Schuster.

Campbell, Tim, and Jeff McMahan. 2010. “Animalism and the Varieties of Conjoined Twinning.” *Theoretical Medicine and Bioethics* 31 (4): 285–301.

Capron, Alexander Morgan. 1987. “Anencephalic Donors: Separate the Dead from the Dying.” *The Hastings Center Report* 17 (1): 5–9. https://doi.org/10.2307/3562433.

Capron, Alexander Morgan, and Leon R. Kass. 1972. “Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal.” *University of Pennsylvania Law Review* 121: 87.

Chappell, Timothy. 2004. “Absolutes and Particulars.” In *Modern Moral Philosophy*, edited by Anthony O’Hear, 95–115. Cambridge: Cambridge University Press. http://www.cambridge.org/uk/catalogue/catalogue.asp?isbn=9780521603263.

———. 2013. “What Have I Done?” *Diametros* 38: 86–111.

Charo, R. Alta. 2001. “Every Cell Is Sacred: The Logical Consequences of the Argument from Potential in an Age of Cloning.” In *Cloning and the Future of Human Embryo Research*, edited by Paul Lauritzen, 82–113. New York: Oxford University Press.

Chaten, Frank. 2014. “The Dead Donor Rule: Effect on the Virtuous Practice of Medicine.” *Journal of Medical Ethics* 40 (7): 496–500.

Chen, Yen-Yuan, and Wen-Je Ko. 2011. “Further Deliberating Burying the Dead Donor Rule in Donation after Circulatory Death.” *The American Journal of Bioethics* 11 (8): 58–59. https://doi.org/10.1080/15265161.2011.591211.

Chisholm, Roderick M. 1970. “The Structure of Intention.” *Journal of Philosophy* 67 (19): 633–647.

———. 1973. *The Problem of the Criterion*. The Aquinas Lecture 1973. Milwaukee: Marquette University Press.

Cholbi, Michael. 2000. “Kant and the Irrationality of Suicide.” *History of Philosophy Quarterly* 17 (2): 159–176.

Choong, Kartina A. 2014. “Losing Faith in the Dead Donor Rule.” *Journal of Medical Law and Ethics* 2 (2–3): 23–35. https://doi.org/10.7590/221354014X14042206275951.

Choper, Jesse. 1982. “Defining Religion in the First Amendment.” *University of Illinois Law Review*, January, 579.

Cochrane, Thomas, and Matt T. Bianchi. 2011. “‘Take My Organs, Please’: A Section of My Living Will.” *The American Journal of Bioethics* 11 (8): 56–58. https://doi.org/10.1080/15265161.2011.583326.

Cochrane, Thomas I. 2011. “Allow the Dying to Donate: Replace the Dead Donor Rule.” In *The Ethics of Organ Transplantation*, edited by Steven J. Jensen, 135–54. Washington, D.C.: Catholic University of America Press. https://login.pallas2.tcl.sc.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=943099&site=ehost-live.

Collins, Mike. 2010. “Reevaluating the Dead Donor Rule.” *Journal of Medicine and Philosophy* 35 (2): 1–26.

Condic, Maureen L. 2016. “Determination of Death: A Scientific Perspective on Biological Integration.” *Journal of Medicine and Philosophy* 41 (3): 257–78. https://doi.org/10.1093/jmp/jhw004.

Coons, Christian, and Noah Levin. 2011. “The Dead Donor Rule, Voluntary Active Euthanasia, and Capital Punishment.” *Bioethics* 25 (5): 236–43.

Cortesini, R. 1966. “Outlines of a Legislation on Transplantation.” In *Ethics in Medical Progress: With Special Reference to Transplantation*, edited by G. E. W Wolstenholme and Maeve O’Connor, 171–81. Boston: Little, Brown.

Coupland, Douglas. 1998. *Girlfriend in a Coma: A Novel*. Harper Collins.

Cruse, Damian, Srivas Chennu, Camille Chatelle, Tristan A Bekinschtein, Davinia Fernández-Espejo, John D Pickard, Steven Laureys, and Adrian M Owen. 2011. “Bedside Detection of Awareness in the Vegetative State: A Cohort Study.” *The Lancet* 378 (9809): 2088–94. https://doi.org/10.1016/S0140-6736(11)61224-5.

Daube, D. 1966. “Transplantation: Acceptability of Procedures and the Required Legal Sanctions.” In *Ethics in Medical Progress: With Special Reference to Transplantation*, edited by G. E. W Wolstenholme and Maeve O’Connor, 188–201. Boston: Little, Brown.

Daube, David. 2008. *The Jottings of David Daube: Reflections from the 20th Century by One of Its Foremost Legal Minds*. Edited by Calum M. Carmichael. New York: YBK Publishers, Inc.

Davis, Richard B. 1995. “The Principlism Debate: A Critical Overview.” *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 20 (1): 85–105. https://doi.org/10.1093/jmp/20.1.85.

DeGrazia, David. 2005. *Human Identity and Bioethics*. New York: Cambridge University Press.

Dennett, Daniel C. 1978. “Where Am I?” In *Brainstorms*. MIT Press.

DeVita, Michael A, and James V Snyder. 1993. “Development of the University of Pittsburgh Medical Center Policy for the Care of Terminally Ill Patients Who May Become Organ Donors after Death Following the Removal of Life Support.” *Kennedy Institute of Ethics Journal*, no. 2: 131.

Di Nucci, Ezio. 2014. *Ethics without Intention*. London; New York: Bloomsbury.

DiSilvestro, Russell. 2010. *Human Capacities and Moral Status*. Vol. 108. Philosophy and Medicine. Dordrecht; Heidelberg; London; New York: Springer.

Donagan, Alan. 1977. *The Theory of Morality*. Chicago: University of Chicago Press.

Dostoevsky, Fyodor. 2004. *The Brothers Karamazov*. Translated by Constance Garnett. New York: Barnes & Noble Classics.

Doyal, Len. 2006. “Dignity in Dying Should Include the Legalization of Non-Voluntary Euthanasia.” *Clinical Ethics* 1 (2): 65–67.

DuBois, J. M., A. D. Waterman, A. Iltis, and J. Anderson. 2009. “Is Rapid Organ Recovery a Good Idea? An Exploratory Study of the Public’s Knowledge and Attitudes.” *American Journal of Transplantation* 9 (10): 2392–99. https://doi.org/10.1111/j.1600-6143.2009.02760.x.

DuBois, James, and Emily Anderson. 2006. “Attitudes toward Death Criteria and Organ Donation among Healthcare Personnel and the General Public.” *Progress in Transplantation* 16 (1): 65–73. https://doi.org/10.7182/prtr.16.1.dv876743k7877rk6.

DuBois, James M. 1999. “Non-Heart-Beating Organ Donation: A Defense of the Required Determination of Death.” *The Journal of Law, Medicine & Ethics* 27 (2): 126–36. https://doi.org/10.1111/j.1748-720X.1999.tb01445.x.

———. 2011. “Dead Tired of Repetitious Debates about Death Criteria.” *The American Journal of Bioethics* 11 (8): 45–47. https://doi.org/10.1080/15265161.2011.583327.
Dworkin, Ronald. 1984. “Rights as Trumps.” In *Theories of Rights*, edited by Jeremy Waldron. Oxford Readings in Philosophy. Oxford, New York: Oxford University Press.
Dyck, Arthur J. 2002. *Life’s Worth: The Case Against Assisted Suicide*. Grand Rapids, MI: Eerdmans.
Eberl, Jason T. 2011. “The Unactualized Potential of PVS Patients.” *APA Newsletter* 11 (1): 14–18.
Elliot, D.W. 1964. “Editorial: When Is the Moment of Death?” *Medicine, Science and the Law* 4 (2): 77–80. https://doi.org/10.1177/002580246400400201.
Elliott, C. 1995. “Doing Harm: Living Organ Donors, Clinical Research and the Tenth Man.” *Journal of Medical Ethics* 21 (2): 91–96.
Engelhardt, H. Tristram. 1975. “Defining Death: A Philosophical Problem for Medicine and Law.” *American Review of Respiratory Disease* 112 (5): 587–90. https://doi.org/10.1164/arrd.1975.112.5.587.
“Ethical Guidelines for Organ Transplantation.” 1968. *JAMA* 205 (6): 341–42. https://doi.org/10.1001/jama.1968.03140320035010.
Ethics Advisory Board. 1979. *HEW Support of Research Involving Human in Vitro Fertilization and Embryo Transfer*. Washington, D.C: Department of Health, Education, and Welfare. https://repository.library.georgetown.edu/bitstream/handle/10822/559350/HEW_IVF_report.pdf?sequence=1&isAllowed=y.
Feinberg, Joel. 1984. *Harm to Others*. Oxford; New York: Oxford University Press.
Fernández-Espejo, Davinia, and Adrian M. Owen. 2013. “Detecting Awareness after Severe Brain Injury.” *Nature Reviews Neuroscience* 14 (11): 801–9. https://doi.org/10.1038/nrn3608.
Finnis, John. 2011. *Natural Law and Natural Rights*. Second. Oxford; New York: Oxford University Press.
Finnis, John, Joseph M. Boyle, and Germain Grisez. 1987. *Nuclear Deterrence, Morality, and Realism*. New York: Oxford University Press.
Finnis, John, Germain Grisez, and Joseph Boyle. 2001. “"Direct and ‘Indirect’: A Reply to Critics of Our Action Theory.” *The Thomist* 65 (1): 1–44.
Fitzpatrick, William. 2003. “Surplus Embryos, Nonreproductive Cloning, and the Intend/Foresee Distinction.” *Hastings Center Report* 33 (3): 29–36. https://doi.org/10.2307/3528435.
Fitzpatrick, William J. 2006. “The Intend/Foresee Distinction and the Problem of ‘Closeness.’” *Philosophical Studies* 128 (3): 585–617.
Flanagan, Owen J. 1991. *The Science of the Mind*. 2nd ed. Cambridge, MA: MIT Press.
Fletcher, Joseph. 1968. “Our Shameful Waste of Human Tissue: An Ethical Problem for the Living and the Dead.” In *Updating Life and Death*, edited by Donald R. Cutler, 1–31. Boston: Beacon Press.

Fletcher, Joseph F. 1954. *Morals and Medicine: The Moral Problems of the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia*. Princeton University Press.
Foot, Philippa. 1967. "The Problem of Abortion and the Doctrine of Double Effect." *Oxford Review* 5: 5–15.
———. 1972. "Morality as a System of Hypothetical Imperatives." *The Philosophical Review* 81 (3): 305–16. https://doi.org/10.2307/2184328.
———. 1984. "Killing and Letting Die." In *Abortion: Moral and Legal Perspectives*, edited by J. Garfield and P. Hennessy, 177–84. Amherst, MA: University of Massachusetts.
Fost, Norman. 1983. Review of *The New Body Snatchers: On Scott's The Body as Property*, by Russell Scott. *Law & Social Inquiry* 8 (3): 718–32. https://doi.org/10.1111/j.1747-4469.1983.tb00890.x.
———. 1999. "The Unimportance of Death." In *The Definition of Death: Contemporary Controversies*, edited by Stuart J. Youngner, Robert M. Arnold, and Renie Schapiro, 161–78. Baltimore: John Hopkins University Press.
———. 2004. "Reconsidering the Dead Donor Rule: Is It Important That Organ Donors Be Dead?" *Kennedy Institute of Ethics Journal* 14 (3): 249–260.
Fox, Renée C. (Renée Claire). 1993. "'An Ignoble Form of Cannibalism': Reflections on the Pittsburgh Protocol for Procuring Organs from Non-Heart-Beating Cadavers." *Kennedy Institute of Ethics Journal*, no. 2: 231.
Fox, Renee C., and Judith P. Swazey. 2013. *Spare Parts: Organ Replacement in American Society*. Second. New Brunswick: Transaction Publishers.
Frey, Jennifer A. Forthcoming. "Practical Knowledge and Double Effect." In *Intention and Double Effect*, edited by John O'Callaghan and Craig Iffland. South Bend: Notre Dame University Press.
George, Robert P., and Christopher Tollefsen. 2008. *Embryo: A Defense of Human Life*. 1st ed. New York: Doubleday.
Giacino, Joseph T., Joseph J. Fins, Steven Laureys, and Nicholas D. Schiff. 2014. "Disorders of Consciousness after Acquired Brain Injury: The State of the Science." *Nature Reviews Neurology* 10 (2): 99–114. https://doi.org/10.1038/nrneurol.2013.279.
Giacomini, Mita. 1997. "A Change of Heart and a Change of Mind? Technology and the Redefinition of Death in 1968." *Social Science & Medicine* 44 (10): 1465–82. https://doi.org/10.1016/S0277-9536(96)00266-3.
Giertz, G. B. 1966. "Ethical Problems in Medical Procedures in Sweden." In *Ethics in Medical Progress: With Special Reference to Transplantation*, edited by G. E. W Wolstenholme and Maeve O'Connor, 139–48. Boston: Little, Brown.
Giubilini, Alberto, and Francesca Minerva. 2013. "After-Birth Abortion: Why Should the Baby Live?" *Journal of Medical Ethics* 39 (5): 261–63. https://doi.org/10.1136/medethics-2011-100411.
Glannon, Walter. 2013. "The Moral Insignificance of Death in Organ Donation." *Cambridge Quarterly of Healthcare Ethics* 22 (02): 192–202. https://doi.org/10.1017/S0963180112000564.

Glasson, J., C.W. Plows, Clarke, J.H. Cosgriff Jr, C.H. Kliger, V.N. Ruff, R.M. Tenery, et al. 1995. "The Use of Anencephalic Neonates as Organ Donors." *JAMA* 273 (20): 1614–18. https://doi.org/10.1001/jama.1995.03520440068039.
Glover, Jonathan. 1977. *Causing Death and Saving Lives*. Harmondsworth; New York: Penguin.
Gonyea, Don. 2017. "From the Start, Obama Struggled with Fallout from a Kind of Fake News." NPR.Org. 2017. http://www.npr.org/2017/01/10/509164679/from-the-start-obama-struggled-with-fallout-from-a-kind-of-fake-news.
Goodwin, Brian C. 1994. *How the Leopard Changed Its Spots: The Evolution of Complexity*. Princeton, NJ: Princeton University Press.
Greco, John. 2002. "Virtues in Epistemology." In *Oxford Handbook of Epistemology*, edited by Paul Moser, 287–315. New York: Oxford University Press.
Gridelli, Bruno, and Giuseppe Remuzzi. 2000. "Strategies for Making More Organs Available for Transplantation." *New England Journal of Medicine* 343 (6): 404–10. https://doi.org/10.1056/NEJM200008103430606.
Grisez, Germain G. 1965. "The First Principle of Practical Reason: A Commentary on the Summa Theologiae, 1-2, Question 94, Article 2 Note." *Natural Law Forum* 10: 168–201.
———. 1970. "Toward a Consistent Natural-Law Ethics of Killing." *American Journal of Jurisprudence* 15: 64–96.
Halley, M, and WF Harvey. 1968. "Medical vs Legal Definitions of Death." *JAMA* 204 (6): 423–25. https://doi.org/10.1001/jama.1968.03140190005002.
Hamburger, J. 1966. "Some General Considerations." In *Ethics in Medical Progress: With Special Reference to Transplantation*, edited by G. E. W Wolstenholme and Maeve O'Connor, 134–38. Boston: Little, Brown.
Hamilton, David. 2012. *A History of Organ Transplantation: Ancient Legends to Modern Practice*. University of Pittsburgh Press.
Harman, Gilbert. 1977. *The Nature of Morality: An Introduction to Ethics*. New York: Oxford University Press.
Harris, C. E. 2012. "The Ethics of Natural Law." In *Conduct and Character: Readings in Moral Theory*, edited by Mark Timmons, 79–92. Boston: Wadsworth.
Harris, John. 1975. "The Survival Lottery." *Philosophy* 50 (191): 81–87.
———. 1978. "Hanink on the Survival Lottery." *Philosophy* 53 (203): 100–101. https://doi.org/10.1017/S0031819100016351.
———. 1992. *Wonderwoman and Superman: The Ethics of Human Biotechnology*. Oxford; New York: Oxford University Press.
———. 2002. "Law and Regulation of Retained Organs: The Ethical Issues." *Legal Studies* 22 (4): 527–49. https://doi.org/10.1111/j.1748-121X.2002.tb00667.x.
Hart, H. L. A., and Tony Honoré. 1985. *Causation in the Law*. Second. Oxford: Oxford University Press.
Hershenov, David B. 2005. "Persons as Proper Parts of Organisms." *Theoria* 71 (1): 29–37. https://doi.org/10.1111/j.1755-2567.2005.tb01003.x.
Hooker, Brad. 2000. *Ideal Code, Real World: A Rule-Consequentialist Theory of Morality*. Oxford, New York: Clarendon Press.

Horan, Dennis J. 1971. “Motion and Brief, Amicus Curiae of Certain Physicians, Professors and Fellows of the American College of Obstetrics and Gynecology in Support of Appellees.”
Hurley, Paul. 2009. *Beyond Consequentialism*. Oxford, New York: Oxford University Press.
Inwagen, Peter van. 2007. “A Materialist Ontology of the Human Person.” In *Persons: Human and Divine*, edited by Peter van Inwagen and Dean Zimmerman, 199–215. Oxford; New York: Oxford University Press.
James, P. D. 1992. *The Children of Men*. First Vintage Books. New York: Vintage.
Jensen, Steven. 2015. *Knowing the Natural Law: From Precepts and Inclinations to Deriving Oughts*. Washington, D.C: The Catholic University of America Press.
Jensen, Steven J. 2010. “Getting inside the acting person.” *International Philosophical Quarterly* 50 (4): 461–71. https://doi.org/10.5840/ipq201050433.
———. 2011. “Killing and Letting Die.” In *The Ethics of Organ Transplantation*, edited by Steven J. Jensen, 170–94. Washington, D.C.: Catholic University of America Press. https://login.pallas2.tcl.sc.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=943099&site=ehost-live.
———. 2014. “Causal constraints on intention: A critique of Tollefsen on the Phoenix Case.” *The National Catholic Bioethics Quarterly* 14 (2): 273–93. https://doi.org/10.5840/ncbq201414230.
Jentzen, Jeffrey M. 2009. *Death Investigation in America: Coroners, Medical Examiners, and the Pursuit of Medical Certainty*. Cambridge, Mass: Harvard University Press.
Joffe, Ari R., Natalie R. Anton, and Allan R. deCaen. 2008. “Survey of Pediatricians: Opinions on Donation after Cardiac Death: Are the Donors Dead?” *Pediatrics* 122 (5): e967–74. https://doi.org/10.1542/peds.2008-1210.
Joffe, Ari R., Joe Carcillo, Natalie Anton, Allan deCaen, Yong Y. Han, Michael J. Bell, Frank A. Maffei, John Sullivan, James Thomas, and Gonzalo Garcia-Guerra. 2011. “Donation after Cardiocirculatory Death: A Call for a Moratorium Pending Full Public Disclosure and Fully Informed Consent.” *Philosophy, Ethics, and Humanities in Medicine* 6 (1): 1–20. https://doi.org/10.1186/1747-5341-6-17.
Jonsen, Albert R. 2001. “Beating up Bioethics.” *Hastings Center Report* 31 (5): 40–45. https://doi.org/10.2307/3527703.
Jotkowitz, A. 2008. “Theological Reflections on Donation after Circulatory Death: The Wisdom of Paul Ramsey and Moshe Feinstein.” *Journal of Medical Ethics* 34 (10): 706–9. https://doi.org/10.1136/jme.2007.023267.
Jox, Ralf J. 2014. “Sketching the Alternative to Brain Death: Dying through Organ Donation.” *The American Journal of Bioethics* 14 (8): 37–39. https://doi.org/10.1080/15265161.2014.925163.
Kaczor, Christopher. 2011. *The Ethics of Abortion: Women’s Rights, Human Life, and the Question of Justice*. New York, NY: Routledge.
Kagan, Shelly. 1988. “The Additive Fallacy.” *Ethics* 99 (1): 5–31.
Kant, Immanuel. 1964. *The Metaphysical Principles of Virtue*. Translated by James Ellington. Bobbs-Merrill.

———. 1990. *Foundations of the Metaphysics of Morals*. Translated by Lewis White Beck. Second. New York: Macmillan.
Kass, Leon R. 2002. "'I Will Give No Deady Drug': Why Doctors Must Not Kill." In *The Case against Assisted Suicide: For the Right to End-of-Life Care*, edited by Kathleen M. Foley and Herbert Hendin, 17–40. Baltimore: Johns Hopkins University Press.
Katz, Jerrold J. 1970. "Interpretative Semantics vs. Generative Semantics." *Foundations of Language* 6 (2): 220–59.
Kaufman, M. H. 2004. "The Embryology of Conjoined Twins." *Childs Nervous System* 20 (8–9): 508–25. https://doi.org/10.1007/s00381-004-0985-4.
Khushf, George. 2010. "A Matter of Respect: A Defense of the Dead Donor Rule and of a 'Whole-Brain' Criterion for Determination of Death." *Journal of Medicine and Philosophy* 35 (3): 330–64. https://doi.org/10.1093/jmp/jhq023.
Koch, Tom. 2012. *Thieves of Virtue: When Bioethics Stole Medicine*. Cambridge, MA: MIT Press.
Koppelman, Elysa R. 2003. "The Dead Donor Rule and the Concept of Death: Severing the Ties That Bind Them." *American Journal of Bioethics* 3 (1): 1 – 9.
Kutner, Luis. 1969. "Due Process of Human Transplants: A Proposal." *University of Miami Law Review* 24: 782.
Landry, Donald W., and Howard A. Zucker. 2004. "Embryonic Death and the Creation of Human Embryonic Stem Cells." *Journal of Clinical Investigation* 114 (9): 1184–86. https://doi.org/10.1172/JCI23065.
Lee, Patrick. 2011. "Substantial Identity, Rational Nature, and the Right to Life." In *Bioethics with Liberty and Justice*, edited by Christopher Tollefsen, 23–40. Philosophy and Medicine 110. Springer Netherlands. https://doi.org/10.1007/978-90-481-9791-0_2.
———. 2015. "Moral Status and the Margins of Human Life." *The American Journal of Jurisprudence* 60 (1): 105–20. https://doi.org/10.1093/ajj/auv008.
———. 2016. "Total Brain Death and the Integration of the Body Required of a Human Being." *Journal of Medicine and Philosophy* 41 (3): 300–314. https://doi.org/10.1093/jmp/jhw005.
Lee, Patrick, and Robert P. George. 2008a. *Body-Self Dualism in Contemporary Ethics and Politics*. New York, NY: Cambridge University Press.
———. 2008b. "The Nature and Basis of Human Dignity." *Ratio Juris* 21 (2): 173–93. https://doi.org/10.1111/j.1467-9337.2008.00386.x.
Levin, Noah Michael. 2013. "The Role of Death in the Moral Permissibility of Solid Organ Procurement after Cardiac Death and Its Implications." Bowling Green State University. https://etd.ohiolink.edu/pg_10?0::NO:10:P10_ACCESSION_NUM:bgsu1383308740.
Levine, Deborah J., Luis F. Angel, Kristi Ternullo, Ann Robertson, Sarah Vines, and Stephanie M. Levine. 2003. "The Use of a Physician-Driven Protocol Can Increase Lung Donation." *Chest* 124 (October): 100S-100S. https://doi.org/10.1378/chest.124.4_MeetingAbstracts.100S.

Lewis, David. 1986. “Causal Explanation.” In *Philosophical Papers*, II:214–240. Oxford University Press.
Liao, S. Matthew. 2006. “The Organism View Defended.” *The Monist* 89 (3): 334–50.
Lizza, John, ed. 2014. *Potentiality: Metaphysical and Bioethical Dimensions*. Baltimore, MD: Johns Hopkins University Press.
Lizza, John P. 2006. *Persons, Humanity, and the Definition of Death*. Baltimore, MD: Johns Hopkins University Press.
———. 2009a. “Commentary on ‘The Incoherence of Determining Death by Neurological Criteria.’” *Kennedy Institute of Ethics Journal* 19 (4): 393–95.
———. 2009b. “Introduction.” In *Defining the Beginning and End of Life: Readings on Personal Identity and Bioethics*, edited by John P. Lizza, 1–19. Baltimore: Johns Hopkins University Press.
———. 2009c. “On the Definition of Death.” In *Defining the Beginning and End of Life: Readings on Personal Identity and Bioethics*, edited by John P. Lizza, 533–50. Baltimore: Johns Hopkins University Press.
———. 2010. “Potentiality and Persons at the Margins of Life.” *Diametros*, no. 26 (December): 44–57. https://doi.org/10.13153/diam.26.2010.414.
———. 2011. “On the Ethical Relevance of Active versus Passive Potentiality.” *APA Newsletter* 11 (1): 22–28.
Luper, Steven. 2009. *The Philosophy of Death*. Cambridge University Press.
Lysaught, M. Therese. 2004. “Respect: Or, How Respect for Persons Became Respect for Autonomy.” *Journal of Medicine and Philosophy* 29 (6): 665–80. https://doi.org/10.1080/03605310490883028.
Machado, Calixto. 2005. “The First Organ Transplant from a Brain-Dead Donor.” *Neurology* 64 (11): 1938–42. https://doi.org/10.1212/01.WNL.0000163515.09793.CB.
MacIntyre, Alasdair C. 1999. *Dependent Rational Animals: Why Human Beings Need the Virtues*. Chicago, Ill.: Open Court.
Macklin, Ruth. 2003. “Dignity Is a Useless Concept.” *BMJ : British Medical Journal* 327 (7429): 1419–20.
Magnus, David C., Benjamin S. Wilfond, and Arthur L. Caplan. 2014. “Accepting Brain Death.” *The New England Journal of Medicine* 370 (10): 891–94. https://doi.org/10.1056/NEJMp1400930.
Malatack, J. Jeffrey, Daniel J. Schaid, Andrew H. Urbach, J. Carlton Gartner, Basil J. Zitelli, Howard Rockette, John Fischer, Thomas E. Starzl, Shunzaburo Iwatsuki, and Byers W. Shaw. 1987. “Choosing a Pediatric Recipient for Orthotopic Liver Transplantation.” *The Journal of Pediatrics* 111 (4): 479–89. https://doi.org/10.1016/S0022-3476(87)80105-1.
Marquis, Don. 1989. “Why Abortion Is Immoral.” *Journal of Philosophy* 86 (4): 183–202.
———. 2010. “Are DCD Donors Dead?” *Hastings Center Report* 40 (3): 24–31.
———. 2014. “Death as a Legal Fiction.” *The American Journal of Bioethics* 14 (8): 28–29. https://doi.org/10.1080/15265161.2014.925160.
Marquis, Donald. 2011. “Why Abortion Is Seriously Wrong: Two Views.” In *Bioethics with Liberty and Justice*, edited by Christopher Tollefsen, 3–22. Philosophy and

Medicine 110. Springer Netherlands. https://doi.org/10.1007/978-90-481-9791-0_1.
Marquis, Donald B. 1991. “Four Versions of Double Effect.” *Journal of Medicine and Philosophy* 16 (5): 515–544.
Marrison, Benjamin. 1988. “Did Doctors Act to Soon in Harvest of Organs in Pamela James Case?” *The Blade*, March 6, 1988.
Marsh, Henry. 2014. *Do No Harm: Stories of Life, Death, and Brain Surgery*. New York: Thomas Dunne Books.
Masek, Lawrence. 2010. “Intentions, Motives and the Doctrine of Double Effect.” *Philosophical Quarterly* 60 (240): 567–585.
Matas, Arthur J. 2008. “Should We Pay Donors to Increase the Supply of Organs for Transplantation? Yes.” *BMJ* 336 (7657): 1342–1342. https://doi.org/10.1136/bmj.a157.
McBryde Johnson, Harriet. 2009. “Unspeakable Conversations, or, How I Spent One Day as a Token Cripple at Princeton University.” In *Peter Singer under Fire: The Moral Iconoclast Faces His Critics*, edited by Jeffrey A. Schaler, 195–205. Peru, IL: Open Court.
McCartney, John, and Kenneth E Wood. 2011. “Medical Management of the Deceased Donor in Solid Organ Transplantation.” In *Primer on Transplantation*, edited by Donald E. Hricik, 3rd ed. Chichester, West Sussex ; Hoboken, NJ: Wiley-Blackwell. http://library.sc.edu/catalog/off campus.html?url=http://site.ebrary.com/lib/usca/Doc?id=10510458.
McMahan, Jeff. 2002. *The Ethics of Killing: Problems at the Margins of Life*. Oxford Ethics Series. New York: Oxford University Press.
———. 2007. “Infanticide.” *Utilitas* 19 (2): 131–159.
———. 2008. “Challenges to Human Equality.” *The Journal of Ethics* 12 (1): 81–104.
———. 2009. “Death, Brain Death, and Persistent Vegetative State.” In *A Companion to Bioethics*, edited by Helga Kuhse and Peter Singer, Second Edition, 286–98. Blackwell Companions to Philosophy. Malden: Wiley-Blackwell.
———. 2013. “Infanticide and Moral Consistency.” *Journal of Medical Ethics* 39 (5): 273–80. https://doi.org/10.1136/medethics-2012-100988.
Meilaender, Gilbert. 1993. “Terra Es Animata: On Having a Life.” *Hastings Center Report* 23 (4): 25–32. https://doi.org/10.2307/3562587.
———. 2001. “The Point of a Ban: Or, How to Think about Stem Cell Research.” *Hastings Center Report* 31 (1): 9–16. https://doi.org/10.2307/3528727.
Menikoff, Jerry. 2003. “Why Being Alive Matters.” *The American Journal of Bioethics* 3 (1): 21–22.
Merker, Bjorn. 2007. “Consciousness without a Cerebral Cortex: A Challenge for Neuroscience and Medicine.” *Behavioral and Brain Sciences*, no. 1: 63.
Mill, John Stuart. 1863. *Utilitarianism*. London: Parker, Son, and Bourn, West Strand.
Miller, Franklin G., and Robert D. Truog. 2008. “Rethinking the Ethics of Vital Organ Donations.” *Hastings Center Report* 38 (6): 38–46.
———. 2009a. “The Incoherence of Determining Death by Neurological Criteria: A Commentary on Controversies in the Determination of Death, a White Paper by

the President's Council on Bioethics." *Kennedy Institute of Ethics Journal* 19 (2): 185–93.
———. 2009b. "The Incoherence of Determining Death by Neurological Criteria: Reply to John Lizza." *Kennedy Institute of Ethics Journal* 19 (4): 397–399.
———. 2012a. *Death, Dying, and Organ Transplantation: Reconstructing Medical Ethics at the End of Life*. Oxford; New York: Oxford University Press.
———. 2012b. "Going All the Way: Ethical Clarity and Ethical Progress." *The American Journal of Bioethics* 12 (6): 10–11. https://doi.org/10.1080/15265161.2012.671890.
Miller, Franklin G., Robert D. Truog, and Dan W. Brock. 2009. "Moral Fictions and Medical Ethics." *Bioethics* 24 (9): 453–60.
———. 2010. "The Dead Donor Rule: Can It Withstand Critical Scrutiny?" *Journal of Medicine and Philosophy* 35 (3): 299–312. https://doi.org/10.1093/jmp/jhq019.
Monti, Martin M., Audrey Vanhaudenhuyse, Martin R. Coleman, Melanie Boly, John D. Pickard, Luaba Tshibanda, Adrian M. Owen, and Steven Laureys. 2010. "Willful Modulation of Brain Activity in Disorders of Consciousness." *New England Journal of Medicine* 362 (7): 579–89. https://doi.org/10.1056/NEJMoa0905370.
Moreland, J. P., and Scott B. Rae. 2000. *Body & Soul: Human Nature & the Crisis in Ethics*. Downers Grove, IL: InterVarsity Press.
Morrissey, Paul E. 2012. "The Case for Kidney Donation before End-of-Life Care." *American Journal of Bioethics* 12 (6): 1-8 8p. https://doi.org/10.1080/15265161.2012.671886.
Moschella, Melissa. 2016a. "Integrated but Not Whole? Applying an Ontological Account of Human Organismal Unity to the Brain Death Debate." *Bioethics* 30 (6): n/a-n/a.
———. 2016b. "Deconstructing the Brain Disconnection–brain Death Analogy and Clarifying the Rationale for the Neurological Criterion of Death." *Journal of Medicine and Philosophy* 41 (3): 279–99. https://doi.org/10.1093/jmp/jhw006.
———. 2017. "Complexity of Defining Death: Organismal Death Does Not Mean the Cessation of All Biological Life." *Journal of Medical Ethics* 43 (11): 754–55. https://doi.org/10.1136/medethics-2017-104363.
Mulgan, Tim. 2004. "Critical Notice of Jeff McMahan, The Ethics of Killing: Problems at the Margins of Life." *Canadian Journal of Philosophy* 34 (3): 443–459.
Munson, Ronald. 2002. *Raising the Dead: Organ Transplants, Ethics, and Society*. Oxford; New York: Oxford University Press.
Murray, J. E., J. H. Harrison, and J. P. Merrill. 1955. "Renal Homotransplantation in Identical Twins." *Surgical Forum* 6: 432–36.
Murray, Joseph E. 1964. "Moral and Ethical Reflection on Human Organ Transplantation." *Linacre Quarterly* 31: 54–56.
———. 2001. *Surgery of the Soul: Reflections on a Curious Career*. Canton, MA: Science History Publications.
Murray, Joseph E., John P. Merrill, Gustave J. Dammin, J. Hartwell Harrison, Edward B. Hager, and Richard E. Wilson. 1964. "Current Evaluation of Human Kidney Transplantation." *Annals of the New York Academy of Sciences* 120 (1): 545–57. https://doi.org/10.1111/j.1749-6632.1964.tb34752.x.

Naci, Lorina, and Adrian M. Owen. 2013. “Making Every Word Count for Nonresponsive Patients.” *JAMA Neurology* 70 (10): 1235–41. https://doi.org/10.1001/jamaneurol.2013.3686.

Nair-Collins, Michael, and Franklin G. Miller. 2016. “Is Heart Transplantation after Circulatory Death Compatible with the Dead Donor Rule?” *Journal of Medical Ethics*, March, medethics-2016-103464. https://doi.org/10.1136/medethics-2016-103464.

———. 2017. “Do the ‘Brain Dead’ Merely Appear to Be Alive?” *Journal of Medical Ethics*, August, medethics-2016-103867. https://doi.org/10.1136/medethics-2016-103867.

National Bioethics Advisory Commission. 1999. *Ethical Issues in Human Stem Cell Research*. Vol. 1. Rockville, ML: National Bioethics Advisory Commission. https://scholarworks.iupui.edu/handle/1805/23.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. “The Belmont Report. Ethical Principles and Guidelines for the Protection of Human Subjects of Research.”

Nelkin, Dana Kay, and Samuel C. Rickless. 2015. “So Close, yet so Far: Why Solutions to the Closeness Problem for the Doctrine of Double Effect Fall Short.” *Noûs* 49 (2): 376–409. https://doi.org/10.1111/nous.12033.

Newsweek. 1968. “Redefinding Death,” May 20, 1968.

Nicholson, Daniel J. 2013. “Organisms ≠ Machines.” *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* 44 (4, Part B): 669–78. https://doi.org/10.1016/j.shpsc.2013.05.014.

———. 2014. “The Machine Conception of the Organism in Development and Evolution: A Critical Analysis.” *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* 48, Part B (December): 162–74. https://doi.org/10.1016/j.shpsc.2014.08.003.

Norris, Richard Cooper. 1895. *An American Text-Book of Obstetrics: For Practitioners and Students*. Saunders.

Nozick, Robert. 1974. *Anarchy, State, and Utopia*. New York: Basic Books.

Nussbaum, Martha. 2008. “Human Dignity and Political Entitlements.” In *Human Dignity and Bioethics: Essays Commissioned by the President’s Council on Bioethics*, edited by Adam Schulman. [President’s Council on Bioethics.

Nussbaum, Martha C. 1997. “Capabilities and Human Rights.” *Fordham Law Review* 66: 273.

———. 2006. *Frontiers of Justice: Disability, Nationality, Species Membership*. Cambridge, MA: Harvard University Press.

———. 2012. *The New Religious Intolerance: Overcoming the Politics of Fear in an Anxious Age*. Cambridge, MA: Harvard University Press.

O’Brien, Matthew B., and Robert C. Koons. 2012. “Objects of Intention: A Hylomorphic Critique of the New Natural Law Theory.” *American Catholic Philosophical Quarterly* 86 (4): 655–703.

Oderberg, David S. 2000. *Applied Ethics: A Non-Consequentialist Approach*. Oxford; Malden, Mass: Blackwell Publishers.

———. 2007. *Real Essentialism*. New York; London: Routledge.
———. 2013. “Synthetic Life and the Bruteness of Causation.” In *Aristotle on Method and Metaphysics*, edited by Edward Feser, 206–35. Palgrave Macmillan.
Oliver, Michael, and Colin Barnes. 2012. *The New Politics of Disablement*. New York: Palgrave Macmillan.
Olson, Eric T. 1997. *The Human Animal: Personal Identity without Psychology*. New York: Oxford University Press.
———. 2001. “Material Coincidence and the Indiscernibility Problem.” *Philosophical Quarterly* 51 (204): 337–355.
———. 2004. “Animalism and the Corpse Problem.” *Australasian Journal of Philosophy* 82 (2): 265–74.
———. 2007. *What Are We? A Study in Personal Ontology*. Oxford; New York: Oxford University Press.
———. 2009. “An Argument for Animalism.” In *Defining the Beginning and End of Life: Readings on Personal Identity and Bioethics*, edited by John P. Lizza, 80–98. Baltimore: Johns Hopkins University Press.
———. 2015. “Personal Identity.” In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Spring 2016. http://plato.stanford.edu/archives/spr2016/entries/identity-personal/.
———. 2016. “The Role of the Brainstem in Personal Identity.” In *Animals: New Essays*, edited by Andreas Blank. Philosophia.
Omelianchuk, Adam. 2015. “'Total Disability’ and the Wrongness of Killing.” *Journal of Medical Ethics* 41 (8): 661–662.
Outka, Gene H. 2002. “The Ethics of Human Stem Cell Research.” *Kennedy Institute of Ethics Journal* 12 (2): 175–213. https://doi.org/10.1353/ken.2002.0012.
Owen, Adrian M., Martin R. Coleman, Melanie Boly, Matthew H. Davis, Steven Laureys, and John D. Pickard. 2006. “Detecting Awareness in the Vegetative State.” *Science* 313 (5792): 1402–1402. https://doi.org/10.1126/science.1130197.
Parfit, Derek. 1984. *Reasons and Persons*. Oxford University Press.
Paterson, Craig. 2008. *Assisted Suicide and Euthanasia: A Natural Law Ethics Approach*. London: Routledge.
Paull II, John. 1995. *The Gospel of Life: On the Value and Inviolability of Human Life*. Washington, D.C.: USCCB Publishing.
Pellegrino, ED. 2002. “Professionalism, Profession and the Virtues of the Good Physician.” *The Mount Sinai Journal of Medicine, New York* 69 (6): 378–84.
Pellegrino, Edmund D. 2005. “Some Things Ought Never Be Done: Moral Absolutes in Clinical Ethics.” *Theoretical Medicine and Bioethics* 26 (6): 469–86. https://doi.org/10.1007/s11017-005-2201-2.
Peterson, Andrew, Loretta Norton, Lorina Naci, Adrian M. Owen, and Charles Weijer. 2014. “Toward a Science of Brain Death.” *The American Journal of Bioethics* 14 (8): 29–31. https://doi.org/10.1080/15265161.2014.925161.
Plows, C.W. 1996. “Rconsideration of Ama Opinion on Anencephalic Neonates as Organ Donors.” *JAMA* 275 (6): 443–44. https://doi.org/10.1001/jama.1996.03530300027023.
Portmore, Douglas W. 2009. “Consequentializing.” *Philosophy Compass* 4 (2): 329–347.

Prehn, Richmond T. 1994. “Cancers Beget Mutations versus Mutations Beget Cancers.” *Cancer Research* 54 (20): 5296–5300.
President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. 1981. *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death*. Washington, D.C.: The Commission : For sale by the Supt. of Docs., U.S. G.P.O.
———. 1983. *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions.* Washington, DC: President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research : For sale by the Supt. of Docs., U.S. G.P.O.
President’s Council on Bioethics. 2002. *Human Cloning and Human Dignity: An Ethical Enquiry*. Washington, D.C: Superintendent of Documents.
———. 2008. *Controversies in the Determination of Death: A White Paper of the President’s Council on Bioethics.* Washington, D.C.: President’s Council on Bioethics.
Puccetti, Roland. 1973. “Brain Bisection and Personal Identity.” *The British Journal for the Philosophy of Science* 24 (4): 339–55.
Quinn, Warren. 1984. “Abortion: Identity and Loss.” *Philosophy and Public Affairs* 13 (1): 24–54.
Rachels, James. 1975. “Active and Passive Euthanasia.” *New England Journal of Medicine* 292 (January): 78–80.
———. 1986. *The End of Life: Euthanasia and Morality*. Studies in Bioethics. Oxford; New York: Oxford University Press.
Ramsey, Paul. 1968. “The Morality of Abortion.” In *Life or Death: Ethics and Options*, edited by Edward Shils, 60–93. Portland, OR: Reed College.
———. 1970. *The Patient as Person: Explorations in Medical Ethics*. New Haven: Yale University Press.
Rawls, John. 1971. *A Theory of Justice*. Cambridge, MA: Belknap Press of Harvard University Press.
Repertinger, Susan, William P. Fitzgibbons, Mathew F. Omojola, and Roger A. Brumback. 2006. “Long Survival Following Bacterial Meningitis-Associated Brain Destruction.” *Journal of Child Neurology* 21 (7): 591–95. https://doi.org/10.1177/08830738060210070401.
Riley, Lauren J. 2011. “A Call to Reject the Neurological Standard in the Determination of Death and Abandon the Dead Donor Rule.” *Notre Dame Law Review* 87: 1749.
Robertson, John A. 1999. “The Dead Donor Rule.” *The Hastings Center Report*, no. 6: 6–14.
Robeyns, Ingrid. 2016. “The Capability Approach.” Edited by Edward N. Zalta. *The Stanford Encyclopedia of Philosophy*. Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/win2016/entries/capability-approach/.
Rodríguez-Arias, David, Maxwell J. Smith, and Neil M. Lazar. 2011. “Donation after Circulatory Death: Burying the Dead Donor Rule.” *American Journal of Bioethics* 11 (8): 36–43.

Rolston, Holmes. 1982. “The Irreversibly Comatose: Respect for the Subhuman in Human Life.” *Journal of Medicine & Philosophy* 7 (4): 337.
Rosen, Frederick. 2005. *Classical Utilitarianism from Hume to Mill*. Routledge.
Rosenkrantz, Gary S. 2015. “Life and Death.” *The Monist* 98 (3): 303–17. https://doi.org/10.1093/monist/onv011.
Ross, William David. 1930. *The Right and the Good*. Edited by Philip Stratton-Lake. Oxford: Oxford University Press.
Sade, Robert M. 2011. “Brain Death, Cardiac Death, and the Dead Donor Rule.” *Journal of the South Carolina Medical Association (1975)* 107 (4): 146–49.
Sade, Robert M., and Andrea Boan. 2014. “The Paradox of the Dead Donor Rule: Increasing Death on the Waiting List.” *The American Journal of Bioethics* 14 (8): 21–23. https://doi.org/10.1080/15265161.2014.925169.
Sartorio, Carolina. 2009. “Causation and Ethics.” In *The Oxford Handbook of Causation*, edited by Helen Beebee, Christopher Hitchcock, and Peter Menzies, 806. Oxford; New York: Oxford University Press.
Schiff, Nicholas D., and Joseph J. Fins. 2007. “Hope for ‘comatose’ Patients.” In *Cerebrum 2007: Emerging Ideas in Brain Science.*, edited by Cynthia A. Read, 185–203. Washington, DC: Dana Press.
Schreiner, G. E. 1966. “Dialysis and Transplantation: Ethical Problems.” In *Ethics in Medical Progress: With Special Reference to Transplantation*, edited by G. E. W Wolstenholme and Maeve O’Connor, 126–33. Boston: Little, Brown.
Schrödinger, Erwin. 1992. *What Is Life? With Mind and Matter and Autobiographical Sketches*. Cambridge University Press.
Schwarz, Stephen D. 1990. *The Moral Question of Abortion*. First edition. Chicago: Loyola University Press.
Scribner, BH. 1964. “Ethical Problems of Using Artificial Organs to Sustain Human Life.” *Transactions - American Society for Artificial Internal Organs* 10: 209–12.
Sen, Amartya. 1982. “Rights and Agency.” *Philosophy and Public Affairs* 11 (1): 3–39.
Shafer-Landau, Russ. 2015. *The Fundamentals of Ethics*. 3 edition. New York: Oxford University Press.
Shah, Seema K., and Franklin G. Miller. 2010. “Can We Handle the Truth? Legal Fictions in the Determination of Death.” *American Journal of Law & Medicine* 36 (4): 540–85. https://doi.org/10.1177/009885881003600402.
Shewmon, D. Alan. 1998a. “‘Brainstem Death,’ ‘Brain Death’ and Death: A Critical Re-Evaluation of the Purported Equivalence.” *Issues in Law & Medicine* 14 (October): 125.
———. 1998b. “Chronic ‘Brain Death’ Meta-Analysis and Conceptual Consequences.” *Neurology* 51 (6): 1538–45. https://doi.org/10.1212/WNL.51.6.1538.
———. 2001. “The Brain and Somatic Integration: Insights into the Standard Biological Rationale for Equating ‘brain Death’ with Death.” *The Journal of Medicine and Philosophy*, no. 5: 457.
———. 2004. “The Dead Donor Rule: Lessons from Linguistics.” *Kennedy Institute of Ethics Journal* 14 (3): 277–300.
———. 2007. “Mental Disconnect: ‘Physiological Decapitation’ as a Heuristic for Understanding ‘Brain Death.’” In *The Signs of Death*, edited by Marcelo Sánchez

Sorondo, 292–333. Pontificiae Academiae Scientiarvm Scripta Varia 110. Vatican City: The Pontifical Academy of Sciences.
———. 2009a. “On Conscious Non-Organisms, Unconscious Persons, and Bisected Person-Organisms.” *American Philosophical Association Newsletter* 9 (1): 14–18.
———. 2009b. “Brain Death: Can It Be Resuscitated?” *Issues in Law & Medicine* 25 (July): 3.
———. 2010. “Constructing the Death Elephant: A Synthetic Paradigm Shift for the Definition, Criteria, and Tests for Death.” *Journal of Medicine and Philosophy* 35 (3): 256–98. https://doi.org/10.1093/jmp/jhq022.
———. 2012. “You Only Die Once: A Reply to Nicholas Tonti-Filippini.” *Communio* 39 (3): 422–94.
Shewmon, D., A.M. Capron, W.J. Peacock, and B.L. Schulman. 1989. “The Use of Anencephalic Infants as Organ Sources: A Critique.” *JAMA* 261 (12): 1773–81. https://doi.org/10.1001/jama.1989.03420120111036.
Shewmon, DA. 1997. “Recovery from ‘Brain Death’: A Neurologist’s Apologia.” *The Linacre Quarterly* 64 (1): 30–96.
Shewmon, DA, Gl Holmes, and PA Byrne. 1999. “Consciousness in Congenitally Decorticate Children: Developmental Vegetative State as Self-Fulfilling Prophecy.” *Developmental Medicine and Child Neurology* 41 (6): 364–74.
Sidgwick, Henry. 1981. *The Methods of Ethics*. 7th ed. Indianapolis: Hackett Publishing Company.
Siminoff, Laura A., Christopher J. Burant, and Said A. Ibrahim. 2006. “Racial Disparities in Preferences and Perceptions Regarding Organ Donation.” *Journal of General Internal Medicine* 21 (9): 995–1000. https://doi.org/10.1111/j.1525-1497.2006.00516.x.
Siminoff, Laura A., Christopher Burant, and Stuart J. Youngner. 2004. “Death and Organ Procurement: Public Beliefs and Attitudes.” *Social Science & Medicine* 59 (11): 2325–34. https://doi.org/10.1016/j.socscimed.2004.03.029.
Simpson, Peter. 1988. “The Definition of Person: Boethius Revisited.” *The New Scholasticism* 62 (2): 210–20. https://doi.org/10.5840/newscholas198862223.
Singer, Peter. 1972. “Famine, Affluence, and Morality.” *Philosophy and Public Affairs* 1 (March): 229–43.
———. 1975. *Animal Liberation: A New Ethics for Our Treatment of Animals*. A New York Review Book. New York: New York Review.
———. 1977. “Utility and the Survival Lottery.” *Philosophy* 52 (200): 218–222. https://doi.org/10.1017/S0031819100023172.
———. 1983. “Sanctity of Life or Quality of Life?” *Pediatrics* 72 (1): 128–29.
———. 1994. *Rethinking Life and Death: The Collapse of Our Traditional Ethics*. 2nd ed. New York: St. Martin’s Griffin.
Singer, Peter, and Karen Dawson. 1988. “IVF Technology and the Argument from Potential.” *Philosophy and Public Affairs* 17 (2): 87–104.
Sinnott-Armstrong, W., and F. G. Miller. 2013. “What Makes Killing Wrong?” *Journal of Medical Ethics* 39 (1): 3–7.
Smart, J. J. C., and Bernard Williams. 1973. *Utilitarianism: For and Against*. Cambridge University Press.

Smith, Barry, and Berit Brogaard. 2003. “Sixteen Days.” *Journal of Medicine and Philosophy* 28 (1): 45–78.
Smith, Wesley J. 2013. *Culture of Death: The Assault on Medical Ethics in America*. San Francisco: Encounter Books.
Starzl, Thomas E. 1967. “Ethical Problems in Organ Transplantation: A Clinician’s Point of View.” *Annals of Internal Medicine* 67 (3_Part_2): 32–36. https://doi.org/10.7326/0003-4819-67-3-32.
———. 1992. *The Puzzle People: Memoirs of a Transplant Surgeon*. Pittsburgh: University of Pittsburgh Press.
Steinberg, A, and M Hersch. 1995. “Decapitation of a Pregnant Sheep: A Contribution to the Brain Death Controversy.” *Transplantation Proceedings* 27 (2): 1886–87.
Stith, Richard. 2004. “The Priority of Respect.” *International Philosophical Quarterly* 44 (2): 165–184.
Suckiel, Ellen Kappy. 1978. “Death and Benefit in the Permanently Unconscious Patient: A Justification of Euthanasia.” *Journal of Medicine and Philosophy* 3 (1): 38–52.
Sulmasy, Daniel P. 1998. “Killing and Allowing to Die: Another Look.” *The Journal of Law, Medicine & Ethics* 26 (1): 55–64. https://doi.org/10.1111/j.1748-720X.1998.tb01906.x.
Sulmasy, DP, and Pellegrino. 1999. “The Rule of Double Effect: Clearing up the Double Talk.” *Archives of Internal Medicine* 159 (6): 545–50. https://doi.org/10.1001/archinte.159.6.545.
Swinburne, Richard. 1997. *The Evolution of the Soul*. Revised. New York: Oxford University Press.
Tännsjö, Torbjörn. 2015. *Taking Life: Three Theories on the Ethics of Killing*. New York, NY: Oxford University Press.
Thaler, Richard H., and Cass R. Sunstein. 2009. *Nudge: Improving Decisions about Health, Wealth, and Happiness*. Revised & Expanded edition. New York: Penguin Books.
Thompson, Michael. 2004. “Apprehending Human Form.” In *Modern Moral Philosophy*, edited by Anthony O’Hear, 47–74. Cambridge: Cambridge University Press. http://www.cambridge.org/uk/catalogue/catalogue.asp?isbn=9780521603263.
———. 2008. *Life and Action: Elementary Structures of Practice and Practical Thought*. Harvard University Press.
Thomson, Judith Jarvis. 1971. “A Defense of Abortion.” *Philosophy & Public Affairs* 1 (1): 47–66.
Tollefsen, Christopher. 2006. “Is a Purely First Person Account of Human Action Defensible?” *Ethical Theory and Moral Practice* 9 (4): 441–60. https://doi.org/10.1007/s10677-006-9024-8.
———. 2008a. “Ten Errors Regarding End of Life Issues, and Especially Artificial Nutrition and Hydration.” In *Artificial Nutrition and Hydration*, edited by Christopher Tollefsen, 213–26. Philosophy and Medicine 93. Springer Netherlands. https://doi.org/10.1007/978-1-4020-6207-0_13.
———. 2008b. “The New Natural Law Theory.” *Lyceum* 10.
———. 2010. “Disability and Social Justice.” In *Philosophical Reflections on Disability*, edited by D. Christopher Ralston and Justin Hubert Ho, 211–27. Philosophy and

Medicine 104. Springer Netherlands. https://doi.org/10.1007/978-90-481-2477-0_13.
Tomlinson, Tom. 1993. “The Irreversibility of Death: Reply to Cole.” *Kennedy Institute of Ethics Journal* 3 (2): 157–65. https://doi.org/10.1353/ken.0.0053.
———. 1998. “Balancing Principles in Beauchamp and Childress.” In . Boston, MA. http://www.bu.edu/wcp/Papers/Bioe/BioeToml.htm.
Toner, Patrick. 2011. “Hylemorphic Animalism.” *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 155 (1): 65–81.
Tooley, Michael. 1983. *Abortion and Infanticide*. Oxford; New York: Clarendon Press; Oxford University Press.
———. 2009. “Personhood.” In *A Companion to Bioethics*, edited by Helga Kuhse and Peter Singer, Second Edition, 129–39. Blackwell Companions to Philosophy. Malden: Wiley-Blackwell.
Truog, Robert D. 1997. “Is It Time to Abandon Brain Death?” *Hastings Center Report* 27 (1): 29–37. https://doi.org/10.1002/j.1552-146X.1997.tb00021.x.
Truog, Robert D., and Franklin G. Miller. 2014. “Changing the Conversation about Brain Death.” *American Journal of Bioethics* 14 (8): 9–14.
Truog, Robert D., Franklin G. Miller, and Scott D. Halpern. 2013. “The Dead-Donor Rule and the Future of Organ Donation.” *New England Journal of Medicine* 369 (14): 1287–89. https://doi.org/10.1056/NEJMp1307220.
Van Inwagen, Peter. 1990. *Material Beings*. Ithaca, N.Y.: Cornell University Press.
Veatch, Robert M. 1975. “The Whole-Brain-Oriented Concept of Death: An Outmoded Philosophical Formulation.” *Journal of Thanatology* 3 (1): 13–30.
———. 1988. “Whole-Brain, Neocortical, and Higher Brain Related Concepts.” In *Death: Beyond Whole-Brain Criteria*, edited by Richard M. Zaner, 171–86. Philosophy and Medicine 31. Springer Netherlands. https://doi.org/10.1007/978-94-009-2707-0_8.
———. 1993. “The Impending Collapse of the Whole-Brain Definition of Death.” *The Hastings Center Report* 23 (4): 18–24. https://doi.org/10.2307/3562586.
———. 2000. *Transplantation Ethics*. Washington, D.C: Georgetown University Press.
———. 2003. “The Dead Donor Rule: True by Definition.” *The American Journal of Bioethics: AJOB* 3 (1): 10–11. https://doi.org/10.1162/152651603322614724.
———. 2005. “The Death of Whole-Brain Death: The Plague of the Disaggregators, Somaticists, and Mentalists.” *Journal of Medicine and Philosophy* 30 (4): 353–378.
———. 2008. “Donating Hearts after Cardiac Death--Reversing the Irreversible.” *The New England Journal Of Medicine* 359 (7): 672–73. https://doi.org/10.1056/NEJMp0805451.
———. 2010. “Transplanting Hearts after Death Measured by Cardiac Criteria: The Challenge to the Dead Donor Rule.” *Journal of Medicine and Philosophy* 35 (3): 313–29. https://doi.org/10.1093/jmp/jhq020.
———. 2015. “Killing by Organ Procurement: Brain-Based Death and Legal Fictions.” *Journal of Medicine and Philosophy* 40 (3): 289–311.
Veatch, Robert M., and Lainie Friedman Ross. 2015. *Transplantation Ethics*. Second. Washington, D.C.: Georgetown University Press.

Velleman, J. David. 1992. “Against the Right to Die.” *Journal of Medicine and Philosophy* 17 (6): 665.
Verheijde, Joseph L., Mohamed Y. Rady, and Joan McGregor. 2007. “Recovery of Transplantable Organs after Cardiac or Circulatory Death: Transforming the Paradigm for the Ethics of Organ Donation.” *Philosophy, Ethics, and Humanities in Medicine* 2 (1): 8. https://doi.org/10.1186/1747-5341-2-8.
Wertin, Thomas M., Mohamed Y. Rady, and Joseph L. Verheijde. 2012. “Antemortem Donor Bilateral Nephrectomy: A Violation of the Patient’s Best Interests Standard.” *The American Journal of Bioethics* 12 (6): 17–20. https://doi.org/10.1080/15265161.2012.671891.
Wierzbicka, Anna. 1975. “Why ‘Kill’ Does Not Mean" Cause to Die": The Semantics of Action Sentences.” *Foundations of Language* 13 (4): 491–528.
Wiesel, Elie. 1958. *Night*. Translated by Marion Weisel. Hill and Wang.
Wilkinson, Dominic, and Julian Savulescu. 2012. “Should We Allow Organ Donation Euthanasia? Alternatives for Maximizing the Number and Quality of Organs for Transplantation.” *Bioethics* 26 (1): 32–48. https://doi.org/10.1111/j.1467-8519.2010.01811.x.
Wilkinson, Martin, and Stephen Wilkinson. 2011. “The Donation of Human Organs.” Edited by Edward N. Zalta. *The Stanford Encyclopedia of Philosophy*. http://plato.stanford.edu/archives/win2011/entries/organ-donation/.
Williams, Glanville Llewelyn. 1957. *The Sanctity of Life and the Criminal Law*. Knopf.
Wolstenholme, G. E. W., and Maeve O’Connor, eds. 1966. *Ethics in Medical Progress: With Special Reference to Transplantation*. London: Churchill.
Wolterstorff, Nicholas. 2008. *Justice: Rights and Wrongs*. Princeton, NJ: Princeton University Press.
Woodruff, M. F. A. 1966. “Transplantation: The Clinical Problem.” In *Ethics in Medical Progress: With Special Reference to Transplantation*, edited by G. E. W Wolstenholme and Maeve O’Connor, 6–23. Boston: Little, Brown.
Woodside, Frank C. 1970. “Organ Transplantation: The Doctor’s Dilemma and the Lawyer’s Responsibility.” *Ohio State Law Journal* 31: 66.
Young, Robert. 2007. *Medically Assisted Death*. Cambridge; New York: Cambridge University Press.
Zohar, Noam J. 2003. “The End of Humanity: Does Circumventing ‘Death’ Help the Cause?” *American Journal of Bioethics* 3 (1): 12–13.