

The Dead Donor Rule and Means-End Reasoning: A Reply to Napier

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I am grateful to Stephen Napier for his sympathetic and thoughtful treatment of the arguments presented in my and Gardiner's paper "Not Dead yet".¹ I am particularly pleased that Napier agrees with the central contention of that paper that the Dead Donor Rule (DDR) should be understood to include a "respect condition" that may rule out particular pre-mortem interventions in the treatment of patients in the course of Donation after Cardiac Death (DCD).² I am also sympathetic to Napier's suggestion that whether or not particular pre-mortem interventions violate this condition will depend upon whether they are properly understood as treating a patient "as a means" in a way that is morally problematic and, moreover, that our paper did not provide a thorough analysis of this condition.

However, *contra* Napier's analysis—and despite not being able to offer a full account of what is involved in treating someone "as a means" in a way that renders such treatment immoral—I still believe that pre-mortem interventions into the care of the patient that are intended to promote successful transplantation (and thus the recovery of a third party) rather than the health of the patient are extremely strong candidates for characterisation as actions that violate the respect condition. Moreover, exploring why this is the case notwithstanding Napier's analysis may make a small but hopefully useful contribution to the project of developing what both Napier and I agree is necessary—a more adequate account of what is involved in treating donors with proper respect in the context of DCD.

Let me begin by noting that our original formulation of our objection to the DCD/Non-Heart Beating organ Donation (NHBD) programs that are emerging around the world was that various of the pre-mortem interventions that are being introduced to reduce warm ischaemic time involved treating living patients "as though they were dead". Indeed, the impetus to write the paper derived from my co-author's observation that procedures that had been developed for, and applied in, patients who had been declared dead on the basis of a diagnosis of brain death were now being applied to patients *before* they were dead and that this change both reflected and reinforced a shift in attitude towards these patients that he (then) found profoundly disturbing.³ The suggestion that the DDR should be understood to prohibit "using living patients solely as a means to an end" is in fact derived from Arnold and Youngner⁴ and we draw upon it to support the claim that practices involved in organ salvage that do not involve the direct killing of the patient might, nonetheless, violate the DDR. To be fair, we do then go on to endorse this way of understanding what is

wrong with premortem interventions to reduce warm ischaemic time in DCD in passing.⁵ However, our main claim remains that we should not treat living patients as though they were dead and that some premortem interventions risk doing precisely that. This formulation has the advantage of highlighting how (we hold) such interventions violate the DDR rather than simply falling foul of an independent moral injunction to respect patients as ends in themselves.

Nevertheless, it's not unreasonable to focus in, as Napier does, on the more familiar expression of a Kantian concern to avoid treating people *solely* as means as the ethical intuition underpinning the more expansive interpretation of the DDR that we advocate. While premortem interventions to facilitate DCD appear, to Gardiner and I, to involve treating living people as though they were dead, the ways we feel it appropriate to treat both living and dead people may change and it may be difficult to reflect critically on these changes unless we are able to draw upon a deeper analysis of the ethics of how we treat each other—of which the Kantian prohibition on treating others “solely as a means” is a paradigmatic example. Thus, as long as we keep it firmly in mind that we are engaged in an analysis of what is required by what Napier labels the “Respect component” of the DDR, then it may indeed prove fruitful to further investigate whether particular interventions do involve treating potential donors solely as a means.

As Napier's paper emphasises, it turns out to be extremely difficult to provide an analysis of just what is involved in treating someone *solely* as a means that neither captures too many of our ordinary human interactions nor excludes modes of relationship that we intuitively feel are profoundly unethical.⁶ I have no ambition to solve this problem here but instead will settle for making some observations about Napier's discussion of whether it is plausible to think that the premortem interventions we focused upon in our original paper use people as a means in a way that *is* morally problematic. Napier is right to point out that our paper actually draws upon two different lines of argument to the conclusion that pre-mortem interventions, such as cannulation and the administering of heparin, treat patients “as a means”: an argument about practitioner attitudes; and, an argument based upon the structure of practical reason evidenced in these interventions.

What does it say about theatre and transplant teams when they start operating on living patients, or administering drugs to them, with the intention of producing a benefit for the transplant recipient rather than for the patient? Or, to put it more baldly, what does it say about them when they conduct these procedures with no intention to benefit the patient?⁷ What does it reveal about—and how does it affect—their attitudes towards these patients? As noted above, Gardiner's intuitions that these attitudes were problematic—and indeed difficult for medical practitioners to entertain given their commitment to the notion that their first duty is to the patient—were the original impetus for our writing on this topic. Given the historical origins of the contested interventions in procedures to facilitate donation after brain death, we argued that these interventions involve treating living patients as though they were dead. However, perhaps it would be more perspicacious simply to insist that those involved in facilitating organ salvage are treating a patient “solely as a means”.

Napier construes our argument in this fashion and then objects that medical practitioners involved in these interventions are not treating the patients *solely* as a means because they also retain a concern for the patient's own ends and well-being, as evidenced by the fact that they do not endorse more radical options to facilitate successful organ salvage.

There is some force to this objection. Yet it is, perhaps, weaker than first appears.

Firstly, one would want to be cautious about inferences about individuals' conscious attitudes on the basis of their omissions, especially in institutional settings. It seems possible, for instance, that a practitioner may have an entirely mercenary and instrumental attitude towards a potential donor in the context of a DCD program, without having considered the possibility of more radical surgical interventions. Indeed, institutional setting for donation after cardiac death, wherein the medical teams involved in the patient's care and in preparation for organ salvage and transplant may be intentionally kept distinct, would seem to militate against those in the organ salvage team keeping the ends of the organ donor in mind. Ultimately, of course, the question of practitioner attitudes is an empirical one. Yet it seems that, while we cannot rule out the presence of a concern for the ends of the donor in practitioners' minds when premortem interventions are conducted, neither can Napier guarantee that these are always present.

Secondly, and more importantly, it would be a perverse consequence of an account of what is involved in treating someone "solely as a means" if one could transform an exploitative relationship of treating someone solely as a means into a non-problematic relationship simply by adding a further intention or attitude to an existing bundle of attitudes. Any such account risks becoming hostage to sophistry. This suggests that an adequate account of what is involved in treating someone solely as a means must make reference to deeper, more objective, features of the relationship between persons than the psychological state of the agent.⁸

These considerations suggest that the second line of analysis that Napier discusses offers better prospects for understanding the nature of treating someone "solely as a means". We might assess the ethics of our relationships with others with reference to the form of practical reasoning that motivates our actions—as Kant seems to have intended when he first set out the categorical imperative. As we observed, and Napier appears willing to concede, premortem interventions to facilitate DCD are justified with reference to the benefit to the organ recipient rather than to the donor. If it were not for the existence of the recipient, these interventions would not take place. Napier objects that this succeeds in showing that premortem interventions are being undertaken *as a means* but not that they involve *treating someone solely* as a means. Again, his objection appears to rest on the thought that the patient is not treated *solely* as a means because other aspects of the way in which they are treated in the hospital setting demonstrate that they are still acknowledged as a member of the "kingdom of ends". Moreover, if the mere fact that a particular relationship with another person would not have existed except for one's own ends were enough to establish that we were treating someone *solely* as a means, this would capture too many of our everyday interactions with each other.

Yet there are several features of the treatment of donors in the course of premortem interventions to facilitate DCD that distinguish them from more familiar cases where we use other people as a means to an end but not solely as a means to an end. In ordinary contexts where we use other people as means to our ends, there exists the communicative possibility of refusal. We acknowledge them as fellow members of the "kingdom of ends" through the fact that if they were to refuse to help serve our ends we would respect this and alter our treatment of them.⁹ However, premortem interventions to facilitate DCD are typically performed on a patient who is unconscious and unable to consent to them. Moreover, there is a specific convention that gives form to what it is to respect someone as a member of the kingdom of ends in medical contexts—the doctrine of informed consent. And, as we argued in our original paper, existing practices whereby individuals indicate their willingness to donate organs—in the UK and, one suspects, in many other jurisdictions—fall well short of what is required to establish informed consent, especially in terms of the information they provide.¹⁰ In the absence of informed consent, then, interventions intended to provide a

benefit for a third party do appear very much as though they are treating the (not-yet-dead) donor solely as a means to this end.

If informed consent—or even informed consent of a surrogate decision maker—to premortem interventions to facilitate DCD were obtained, this objection would lapse. Indeed, these interventions would then have the character of surgery (or drug treatment) performed on a living patient with their consent. Obtaining proper informed consent to premortem interventions would also strengthen the argument that these interventions are justified in order to promote the donor's ends and not just the recipient's. If the DDR is properly interpreted to prohibit treating living patients solely as a means to an end, premortem interventions to facilitate donation for which consent has been attained would not violate the DDR.

An important result that has emerged from this exchange, however, is that there remains an element of intuitive force to our original objection to premortem interventions to facilitate DCD—that we should not treat the living as though they were dead—that is not captured by the essentially Kantian interpretation of the DDR as prohibiting treating the donor solely as a means to an end—or at least not by an interpretation of this criterion that focuses on informed consent. In fact, our original paper treated the possibility of premortem interventions with appropriate consent in the context of the discussion of the implications of *abandoning* the DDR.¹¹ With the benefit of further reflection, I now think that this treatment was inconsistent with our own discussion of how premortem interventions risk treating the donor solely as a means to an end. However, the intuition that was driving our discussion, which still seems to me well founded, was that if informed consent was all that was required to render premortem interventions compatible with the DDR then this would imply that, with appropriate consent, it would not violate the DDR to completely surgically expose a suitably anaesthetised patient's organs in preparation for organs salvage once they had been declared dead after their heart had stopped beating. Yet surely this is just the sort of nightmarish scenario, wherein living patients are dissected—albeit, *ex hypothesi*, not actually killed—for the sake of procuring their organs that the DDR was supposed to rule out? That is to say, even if the living were willing to consent to be treated as though they were dead there is sufficient content to the latter characterisation to call into question the ethics of doing so.

The DDR attempts to draw a strict line between the way we treat the living and the dead and to reassure the living that their interests will not be sacrificed for the sake of securing organs for transplantation.¹² The intuition that we should maintain this distinction is not exhausted by the idea that we should always secure consent for procedures performed upon living patients. There may be some procedures that it would be wrong to carry out even with consent. If we treat the living as though they were dead we undermine a distinction that is both essential to ethical transplantation and to public support for transplantation and donation programs. Given that one of the most important features of living persons is their capacity to set their own ends, it is natural to describe these problematic interventions as treating the patient as a means. However, in doing so we must avoid the temptation to think that obtaining consent from the patient would invalidate this description.

Whether or not the relatively simple premortem medical interventions that are currently used in DCD programs to reduce the period of warm ischaemia fall into this category is a further question. We argued that they did: Napier begs to differ. Apart from insisting that soliciting informed consent for these procedures would not settle the matter, I have little further to add here in relation to this particular question. However, I *would* observe that in answering it we must be mindful of the possibility that our intuitions may have been affected by a pernicious policy “creep” within medical institutions that itself is driven by the

(understandable) desire to secure more and more organs for transplant.¹³ The DDR is supposed to serve as a barrier to this process: it would be a disaster if our interpretation of the DDR itself should be affected by it.¹⁴

¹ Napier, S. The Dead Donor Rule and means-end reasoning: A reply to Gardiner and Sparrow. *Cambridge Quarterly of Healthcare Ethics* 2010;##(##):##-##.

² Sparrow R, Gardiner D. Not dead yet: Controlled Non-Heart Beating Organ Donation, consent, and the Dead Donor Rule. *Cambridge Quarterly of Healthcare Ethics* 2010;19(1): 17-26.

³ Ironically, Dr Gardiner, who is an intensive care specialist, has now moved into a role where he is involved in promoting organ donation. His concern to encourage sound ethical practice was an important consideration in his decision to take on this role.

⁴ Arnold RM, Youngner SJ. The dead donor rule: should we stretch it, bend it, or abandon it? *Kennedy Institute of Ethics Journal* 1993;3(2):263–78.

⁵ See note 2, Sparrow, Gardiner 2010:21.

⁶ But see, Cocking D, Oakley J. Medical experimentation, informed consent and using people. *Bioethics* 1994; 8(4): 293-311.

⁷ This description is, of course, controversial. In particular, as we noted in our original discussion, it might be argued that these procedures are intended to produce a benefit for the donor by helping them to satisfy their desire to donate a “good” organ. However, as we treated this suggestion and its relationship to the question of the nature of the consent required for pre-mortem procedures in our original discussion and because Napier appears to concede that these procedures are not—at least primarily—directed towards the good of the patient, I will not discuss the matter further here and will instead refer the interested reader to our original paper.

⁸ Again, see, note 6, Cocking, Oakley 1994.

⁹ I am not claiming here that this is an exhaustive definition of what it is not to treat someone solely as a means, only that this suffices to illustrate the relevant contrast with DCD.

¹⁰ Napier is mistaken when he attributes to us a concern that the UK was proceeding on the basis of presumed consent for organ donation (it does not). Our worry, rather, is that registration on the UK organ donor registry falls well short of what is required to establish informed consent to a medical procedure.

¹¹ See note 2, Sparrow, Gardiner 2010:21.

¹² Judicial Council of the American Medical Association. Ethical guidelines for organ transplantation. *Journal of the American Medical Association* 1968 Aug 5;205(6):341–2.

¹³ A possibility that Renee Fox held was already being realised at the very outset of the debate about non-heart -beating transplantation. See, Fox, RC. “An ignoble form of cannibalism”: Reflections on the Pittsburgh protocol for procuring organs from non-heart-beating cadavers. In: Arnold, RA, Youngner, SJ, Schapiro, R, Spicer, CM, eds. *Procuring Organs for Transplant: The Debate over Non-Heart Beating Cadaver Protocols*. Baltimore and London: The John Hopkins University Press; 1995: 155-163.

¹⁴ This paper was begun at Monash University and completed while I was a Visiting Fellow at the Centre for Biomedical Ethics at the National University of Singapore. I wish to thank Alastair Campbell, Dale Gardiner, Krishnakumar Madhavan, and Justin Oakley, for comments and discussion that have improved the paper.