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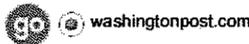
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The Doctors Who Are Redefining Life and Death

By William Saletan

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Think being the next president would be a brutal job? Imagine being a transplant surgeon. You can't tell the parents of a dying kid when to pull the plug, but you have to be there, ready, the minute he expires. You have to wait until he's dead, but not so long that his organs become useless. You can give him drugs to keep his organs healthy, but you mustn't technically revive him. And you can't remove and restart his heart until it's been declared kaput.

Pick up a recent issue of the New England Journal of Medicine, and you'll see the far edge of this tortured world. In the journal, doctors at Children's Hospital in Denver describe how they removed hearts from infants 75 seconds after they stopped. The infants were declared dead of heart failure, even as their hearts, in new bodies, resumed ticking.

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Is this wrong? We like to think that moral lines are fixed and clear: My heart is mine, not yours, and you can't have it till I'm dead. But in medicine, lines move. "Dead" means irreversibly stopped, and stoppages are increasingly reversible. And when life support ends, says one bioethicist, "not using viable organs wastes precious life-saving resources" and "costs the lives of other babies." Failure to take body parts looks like lethal negligence.

How can we get more organs? By redefining death. First we coined "brain death," which let us take organs from

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people on ventilators. Then we proposed organ retrieval even if non-conscious brain functions persisted. Now we have "donation after cardiac death," the rule applied in Denver, which permits harvesting based on heart, rather than brain, stoppage.

But stoppage is complicated. There's no "moment" of death. Some transplant surgeons wait five minutes after the last heartbeat; others wait two. The Denver team waited 75 seconds, reasoning that no heart is known to have self-restarted after 60 seconds. Why push the envelope? Because every second counts. Mark Boucek, the doctor who led the Denver team, says that waiting even 75 seconds makes organs less useful.

So how can death be declared based on irreversible heart stoppage when the plan is to restart that heart in a new body? Boucek offers two answers. First, even if the heart resumes pumping in a new body, it couldn't have done so in the old one. (That used to be true, but today, hearts can be restarted by external stimulation well after two or even five minutes.) Second, Boucek says the heart is dead because the baby's parents have decided not to permit resuscitation. In other words, each family decides when its loved one is dead. In a commentary attached to the Denver report, another ethicist proposes extending this idea -- letting each family decide not just whether to resuscitate but also at what point organs can be harvested. Brain death? Cardiac death? Persistent vegetative state? Death is whatever you say it is.

Robert Truog, an ethicist who supports the Denver protocol, says this redefinition of death has gone too far. Let's accept that we're taking organs from living people and causing death in the process, he argues. This is ethical as long as the patient has "devastating neurologic injury" and has provided, through advance directive or a surrogate, informed consent to be terminated this way. We already let surrogates authorize removal of life support, he notes. Why not treat donations similarly? Traditional safeguards, such as the separation of the transplant team from the patient's medical team, will prevent abuse. And the public will accept the new policy since surveys suggest we're not hung up on whether the donor is dead.

But down that road lies even greater uncertainty. How devastating does the injury have to be? If death is vulnerable to redefinition, isn't "devastating" even more so? The same can be asked of "futility," the standard used by the Denver team to select donors. Is it safe to base lethal decisions on the ebb and flow of public opinion, particularly when the same surveys show confusion about death standards? And can termination decisions really be insulated from pressure to donate? Even if each family makes its own choice, aren't we loosening standards for termination precisely to get more organs?

Modern medicine has brought us tremendous power. Boundaries such as death, heart stoppage and ownership of organs have guided our moral thinking because they seemed fixed in nature. Now we've unmoored them. I'm a registered donor because I believe in the gift of life and think that the job of providing organs falls to each of us. So does the job of deciding when we can rightly take them.

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