contemporary Christians. In the service of the same nice Christianity that failed to stop Hitler, Gushee fears calling sin sin, a sad irony for an ethicist.

Catholics would do better to read Evangelium vitae (1995). Here Pope St. John Paul II lays out the ethical issues surrounding abortion and other practices that cheapen human life. He says, “Sometimes it is precisely the mother herself who makes the decision and asks for the child to be eliminated, and who then goes about having it done” (n. 58). In the next paragraph he notes again the moral responsibility of the mother even while admitting to complex psychological or societal factors:

It is true that the decision to have an abortion is often tragic and painful for the mother, insofar as the decision to rid herself of the fruit of conception is not made for purely selfish reasons or out of convenience, but out of a desire to protect certain important values such as her own health or a decent standard of living for the other members of the family. Sometimes it is feared that the child to be born would live in such conditions that it would be better if the birth did not take place. Nevertheless, these reasons and others like them, however serious and tragic, can never justify the deliberate killing of an innocent human being. (n. 58)

Despite his many keen insights, at points like this, Gushee compromises his Christian ethics too much.

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The Ethics of Organ Transplantation
edited by Steven J. Jensen

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Of the many advances achieved by modern medicine, few enjoy as much favor as organ transplantation. For those receiving organs, there is the gift of new life; for those mourning the loss of a loved one, the consolation that some good has come of out of their overwhelming loss. When we look closely at the sources of this favor, however, there is more officialdom about it than popular sentiment. Many who are enthusiastic about others donating their organs are cautious when it comes to donating their own. Of course, there might be nothing more to this than a perfectly natural squeamishness. But as a number of the essays in Steven Jensen’s Ethics of Organ Transplantation make abundantly clear, there are good reasons to wonder whether organ transplantation as it is currently practiced is the unalloyed good that its promoters would have us believe.

One of the strengths of this volume is that it captures the complexity of the moral issues surrounding organ transplantation. It does this by including essays that range across the spectrum of possible views on the issue and bringing them into dialogue with each other. The result, rather than a disconnected assortment of differing viewpoints, is instead an extended conversation between experts, one that is highly informative, sometimes inspiring, and often disturbing.

The essays in this volume “arose out of a conference held in 2009 at the University of St. Thomas, in Houston, Texas, at which philosophers, theologians, lawyers, and medical doctors gathered to consider the ethical questions surrounding organ transplantation” (xxi). Preceded by Jensen’s lucid and insightful introduction, they are organized into five parts, each generally dealing with a major
issue: (1) brain death, (2) donation after cardiac death, (3) the dead-donor rule, (4) whether organs are gifts and therefore never to be sold or conscripted, and (5) relevant corollaries and history.

Before the advent of non-paired organ transplantation, cardiopulmonary death—when the heart and lungs irreversibly cease functioning—was considered the death of the person. But along with the promise of lives saved through organ transplantation came the urgency to find enough donors to meet the need. Waiting for a person’s heart to stop and to stop long enough for a declaration of death often meant the loss of vital organs. In 1968, the Harvard Medical School’s Ad Hoc Committee to Examine the Definition of Brain Death issued a report arguing for a change in the legal and medical definition of death that would be centered on the brain instead of the heart. The reasoning behind the committee’s recommendation was partly aimed at increasing the number of donor organs. In essence, their thinking seemed to be, “If removing the heart of a live person is unacceptable because it kills the person, then perhaps we can find some dead people with beating hearts,” as Jensen puts it rather neatly. “Enter brain death” (xii).

Among those critical of brain death, the best known is UCLA neurologist Alan Shewmon. On the basis of evidence supplied by numerous cases of brain-dead patients who “showed evidence of somatic integration and holistic properties” (30) over the course of months and in some cases even years, Shewmon argues that “somatic integrative unity is not a top-down imposition from a ‘central integrator’ [i.e., the brain] on an otherwise unintegrated collection of organs [as brain death requires]. Rather, it is a non-localized emergent property from the mutual interaction among all the parts of the body” (38).

One might well wonder how a brain-dead body can be suitably disposed to be informed by a rational soul. But in the case of the brain-dead patient who needs little more than a ventilator and normal care to live, it is hard to avoid the conclusion that he enjoys the kind of somatic integration only the human soul can provide. Yet as supportive as the evidence may be for Shewmon’s eminently humane position, Jason Eberl in “Ontological Status of Whole-Brain-Dead Individuals” gives us reason to draw a very different conclusion. If we could keep someone’s decapitated body alive, we would nevertheless consider him very much deceased. Why then consider brain-dead individuals to be living persons? This of course depends on brain-dead individuals being analogous to decapitated bodies. But are they? L.M. Whetstine, in “Ethical Concerns with Rapid Organ Recovery Ambulances,” gives us reason to pause, maintaining that “[a] patient who respires and circulates blood, who can regain hemodynamic stability, metabolize and excrete waste, exhibit some brain function including measurable EEG output and an intact neurohormonal pathway, raise her temperature with the help of blankets, gestate a fetus, and react to surgical incision does not fulfill the definition of death on biological grounds” (130).

Setting questions about brain death aside, it is a fact that the widespread adoption of brain-death criteria did not close the gap between the need for organs and their supply. It failed for the simple reason that “brain death is relatively rare. Approximately two and a half million persons die in the United States each year. Only eleven thousand to thirteen thousand of these meet BD criteria, and not all of them are medically suitable for donation. The incidence of BD, furthermore, is falling, so few people are likely to be able to donate in this way” (137).

And so we come to donation after cardiac death (DCD), also known as the Pittsburgh protocol, named after the University of Pittsburgh Medical Center, where it was first introduced. Rather than waiting for the brain to die, the practitioners of DCD wait for what is variously understood to be the irreversible loss of cardiopulmonary function, a much more common occurrence. I say “variously understood” because there is no agreement on when precisely cardiopulmonary function may be said to have been irreversibly lost. In “Organ Donation following Cardiac Death,” Christopher Kaczor notes that “in many ICUs, patients are certified dead after less than two minutes of asystole. The
Pittsburgh protocol for DCD draws the line at two minutes, the Institute of Medicine at five minutes, the Maastricht protocol at ten minutes,” with Alan Shewmon’s standard of “twenty to thirty minutes after loss of circulation” being “the most demanding” of which Kaczor “is aware” (110), but not one practiced anywhere, as far as I was able to determine from reading any of the essays in the volume. Then there is the question of what it means to suffer such a loss. It cannot mean that the heart and lungs or any of the other vital organs have permanently lost their ability to function, for that would render them useless for transplantation. Such reasoning might seem self-serving, but Kaczor argues that irreversibility is a function of the person as a whole, not simply of his organs. When a person’s life can no longer be sustained by his organs, then we may say that his organs, too, have suffered an irreversible cessation of function for that person. Outside of him, in a recipient, they may function perfectly well. But even if this is correct, there is still the question of whether the irreversible loss of cardiopulmonary function is sufficient to constitute death, a point Whetstone drives home in his essay. Getting this right is the difference between taking organs from a lifeless cadaver and taking them from a living person.

All of this is a problem, of course, only if we accept the dead-donor rule, the bedrock moral principle of organ transplantation from its earliest days. According to this rule, “vital organs may be taken only from dead patients, and . . . living patients must not be killed by organ retrieval” (135). In “Allowing the Dying to Donate,” Thomas I. Cochrane urges us to relax the dead-donor rule where those dying and wishing to donate their organs are concerned. His argument for the moral licitness of doing so is based on what he takes to be the equivalence between killing and letting die. No one seems to mind that doctors routinely allow their patients to die. Why not, then, allow them to end their dying patients’ lives through the removal of their organs if that is what their patients want? As Cochrane puts it, “Honoring my preference by allowing me to donate my organs and die rather than simply die after life support has been stopped] would do nothing but show respect for my life, my interests, and my dignity. It’s not at all clear why simply dying (in this case, of dehydration, or if I were on a ventilator, of asphyxia) would be the more dignified or defensible course” (141).

But is killing equivalent to letting die? In “Killing and Letting Die,” Jensen argues that it is not and that the difference between the two is morally significant. What is wrong with the so-called benevolent suicide or euthanasia of a patient who wills his death through organ donation is that he adopts a morally indefensible attitude toward himself. In Jensen’s words, “The person who kills himself thinking to help others . . . treats himself as a mere utility. He subjects his own good, subordinating it as useful for some further goal. Whatever he gives, then, he does not give himself. He does not give what a true friend gives. Would a true friend accept such a sacrificial suicide? If she does, then is she really worth it?” (190).

Which brings us to part 4. Another proposed solution to the shortage of organs is to move away from the paradigm that views organs as gifts to one that views them as commodities to be bought and sold and, when necessary, even conscripted. The free market solves problems of scarcity all the time. Maybe it could solve this one, too. The problem with this solution, however, is that it is impossible to treat a person’s organs as commodities without treating him as a commodity as well, a point Thomas Hurley argues brilliantly in his essay “The Meaning of Gift in Organ Transplantation.” The person who is free to sell his own organs is free to sell his own life. Or, as Hurley says, autonomy understood in such terms, when followed out logically, leads inevitably to “the permissibility of straightforward suicide for the sake of donation, even by an otherwise healthy person” (227–228). And if a person may sell his organs, might not the state conscript his organs upon death even against his stated wishes? Taking this a step further, what is there to prevent the state from invoking a kind of ultimate eminent domain and conscripting a person’s organs while he is still using them? Were the world
a better place, we might dismiss such dark thoughts as paranoid fantasies, but as David Matas shows in “Ethics of Contact with China on Transplants,” the Chinese have made it impossible to exaggerate the dangers of losing sight of the giftedness of human life. With the collusion of the international community, the Chinese Communists have given new meaning to the term “Red China,” turning the murder of thousands of persecuted Falun Gong practitioners, among others, into a lucrative trade in organs.

With horrors like this on display, I found it somewhat comforting to learn that the Church has shown a reluctance to embrace organ transplantation as an unalloyed good. As Romanus Cessario notes in “Organ Donation and the Beatific Vision,” the Church has been rather cautious in her pronouncements on organ donation. Although this caution owes much to the Church’s concern for the dignity of all human persons, including the dying, there is in it also a profound recognition of the order of charity. According to this order, we must love first things first and second things second if we are to love first and second things well. Christian love is not egalitarian. Rather, “it displays preferences for one neighbor over the other. This inevitably preferential mode of loving takes into account both God and the person who loves: ‘the nearer the “object” is to either of these,’ says Aquinas, ‘the dearer it is’” (208). Only such a caritative ethics can serve as a bulwark against the “tsunami of moral relativism that now threatens to submerge the moral conscience of the Western world” (197–198), a moral relativism that would shame us for withholding our organs if it saw fit to demand them of us.

More could be said about this important collection of essays. Like the topics it broaches, it cannot be ignored. If I could, I would put a copy in the hands of every legislator and educator, religious leader, and opinion maker. For although it would make them uncomfortable, it might also make them wiser.

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**A Defense of Dignity:**

*Creating Life, Destroying Life, and Protecting the Rights of Conscience*

by Christopher Kaczor

University of Notre Dame Press, 2013, paperback, $30.00


The use of the term “dignity” has been hijacked by those hoping to pervert its moral significance, particularly when it comes to bioethical debates. Consider the public discourse over physician-assisted suicide and the efforts by those who seek to mask its cruel reality with the phrase “death with dignity.” In recent memory, medical ethicist Ruth Macklin has declared dignity to be a “useless concept,”1 and Harvard psychologist Steven Pinker has lamented “the stupidity of dignity.”2 In response, Christopher Kaczor’s *A Defense of Dignity: Creating Life, Destroying Life, and Protecting the Rights of Conscience* is both a welcome rebuttal to their arguments and an apologetic for the robust, thick conception of human dignity in medical ethics today.

In this volume, Kaczor—William E. Simon Visiting Fellow at Princeton University, a professor of philosophy at Loyola Marymount University in Los Angeles, and a columnist for the NCBQ—offers a rigorous analysis of some of the most critical areas