**Public comment of The National Catholic Bioethics Center et al. on Proposal to clarify requirements for pronouncement of death by the Organ Procurement and Transplantation Network**

March 5, 2024

Thank you for the opportunity provide comment to the Organ Procurement and Transplantation Network (OPTN) on *Public Comment Proposal: Clarify Requirements for Pronouncement of Death*. The National Catholic Bioethics Center (NCBC) supports efforts by the OPTN to increase public trust in the organ/tissue transplantation process. Recent examples include increasing equity in kidney transplantation by adjusting geographical factors for organ allocation and strengthening transparency and accountability by collaborating with the US Department of Health and Human Services on the Organ Procurement and Transplantation Network Modernization Initiative.[1] However, despite its contribution to this work, the OPTN's current proposal on the pronouncement of death does not sufficiently promote the patient-donor's integral human good, on which public trust in organ/tissue transplantation is premised. To achieve this goal, the policies, practices, and procedures of the OPTN, organ transplantation organizations (OPOs), and hospitals related to *conflicts of interest* and *pronouncement of death* must explicitly affirm the following (without prejudice to other OPTN policies): The donor must be dead before his or her organs/tissues are procured. The patient's living will or advance directive and the free and informed consent of surrogates and families for organ/tissue donation must be respected. Health care team members' professional judgment when determining whether and how to pronounce death must be guaranteed, when that judgment is consistent with scientific standards indicating irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain.

The NCBC is a nonprofit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences. The NCBC serves numerous health care agencies in their development and analysis of policies and protocols, including protocols for implementing OPTN policies on organ/tissue donation and transplantation that

[1] Organ Procurement and Transplantation Network, "Two-Year Monitoring Report Continues to Show Improvements in Equity in Access to Kidney Transplants for Several Key Population," new release, July 6, 2023, https://optn.transplant.hrsa.gov/news/two-year-monitoring-report-continues-to-show-improvements-in-equity-in-access-to-kidney-transplants-for-several-key-populations/; and Health Resources and Services Administration, "HRSA Announces Organ Procurement and Transplantation Network Modernization Initiative," new release, March 22, 2023, https://www.hrsa.gov/about/news/press-releases/organ-procurement-transplantation-network-modernization-initiative.

comply with the *Ethical and Religious Directives for Catholic Health Care Services.* The NCBC has thirteen hundred members throughout the United States. Furthermore, the NCBC provides consultations to hundreds of institutions and individuals seeking its opinion on the appropriate application of Catholic moral teaching in the delivery of health care, including organ/tissue procurement and transplantation.

The NCBC supports the OPTN's proposal to update *Policy 2.14.A Conflicts of Interest* and *Policy 2.15.G Pronouncement of Death* to clarify that "donor hospital healthcare professionals who declare the death of a potential deceased donor cannot be involved in any aspect of the organ recovery procedure or transplantation of that donor's organs."[2] This revision can help remove potential conflicts of interest between health care professionals' primary duty to their patients and the obligations they have assumed as representatives of an OPO. In turn, this can increase public trust in the pronouncement of death. However, this criterion of independence is not sufficient to maintain ethical integrity and consequent public trust. Too narrow a focus on this source of conflict can obscure other factors "during patient care and potential donor evaluation, which could compromise the examination of the donor,"[3] such as the perception that physicians sometimes pressure family members to consent to organ/tissue donation.[4]

Despite the noble goal of savings lives by increasing the number of organs available for transplantations, overly aggressive organ procurement practices can irreparably harm public trust, which is premised less on avoiding conflicts of interest, ensuring consistent policies, and clarifying the roles of health care team members than on guaranteeing an organ/tissue transplantation process that protects human dignity and promotes solidarity and subsidiarity. Moreover, ethical criteria must guide all technological development. Consequently, in addition to the proposed revisions, and without prejudice to other policies,[5] we urge the OPTN to explicitly affirm the following principles in *2.14.A Conflicts of Interest* and *2.15.G Pronouncement of Death*.

*All hospital and OPO practices and procedures for the pronouncement of death must ensure that the donor is truly dead before vital organs/tissues may be taken and that the act of organ/tissue*

[2] Organ Procurement and Transplantation Network, Organ Procurement Organization Committee, *Public Comment Proposal: Clarifying Requirements for Pronouncement of Death* (Richmond, VA: United Network for Organ Sharing, 2024), 2.
[3] Organ Procurement Organization Committee, *Clarifying Requirements for Pronouncement of Death*, 4.
[4] Nancy Kentish-Barnes et al., "Grief Symptoms in Relatives Who Experienced Organ Donation Requests in the ICU," *American Journal of Respiratory and Critical Care Medicine* 198.6 (September 15, 2018): 751–758, doi: 10.1164/rccm.201709-1899OC.
[5] See, for example, *Policy 2.14.E Deceased Donor Authorization Requirement*, *Policy 2.15.D Consent for DCD*, and *Policy 2.15.E Authorization for DCD*.

*procurement does not result in the death of the donor*.[6] These practices and procedures must be governed by the precautionary principle to preclude "the slightest suspicion of arbitration [arbitrariness]."[7] This duty is entailed by the sanctity of life and the dignity of the patient. Respect for these principles—which are grounded in the human person's openness to relationality and "unrepeatable and inviolable uniqueness"[8]—requires us to remember that the donor is, first and foremost, a patient who has entered into a healing relationship with the health care team, whose primary responsibility is to use their "professional competence most effectively to maintain or restore the patient's health."[9] At the end of life, this includes the recognition that "the task of medicine is to care even when it cannot cure."[10] This healing relationship is guided by the principle of solidarity, "*a firm and persevering determination* to commit oneself to the . . . good of all and of each individual, because we are *all* really responsible for *all*."[11] The patient is an end in himself or herself and, therefore, must not be "manipulated for ends that are foreign to his own development."[12]

*OPO representatives and health care team members must obtain free and informed consent from the patient or, if the patient is no longer competent, the surrogate or family for organ/tissue procurement, acting consistently with the known will of the patient. The patient's or surrogate's decision should be respected, whether it be in favor of or against organ/tissue donation*. Fundamentally, this principle obtains its force from the right and duty of the patient to direct his or her own medical treatment and, in matters of organ donation, to make a truly free gift of self. The health care team and the family "have no separate or independent right where the patient is concerned,"[13] and the family is "in a position to know best the patient's wishes."[14] This hierarchy is guided by the principle of

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[6] US Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018), no. 64; see also no. 60.
[7] Benedict XVI, Address to Participants at an International Congress Organized by the Pontifical Academy for Life (November 7, 2008), https://www.vatican.va/content/benedict-xvi/en/speeches/2008/november/documents/hf_ben-xvi_spe_20081107_acdlife.html.
[8] Pontifical Council for Justice and Peace (PCJP)*, Compendium of the Social Doctrine of the Church* (Vatican City: Libreria Editrice Vaticana, 2004), nos. 130-131.
[9] USCCB, *Ethical and Religious Directives*, part 3, introduction.
[10] USCCB, *Ethical and Religious Directives*, part 5, introduction.
[11] PCJP, *Compendium of Social Doctrine*, no. 133, emphasis original, quoting John Paul II, *Sollicitudo rei socialis* (December 30, 1987), no. 38, emphasis added.
[12] PCJP, *Compendium of Social Doctrine*, no. 193.
[13] Pius XII, "The Prolongation of Life: An Address to an International Congress of Anesthesiologists, November 24, 1954," trans. the National Catholic Welfare Conference News Service and the editors of *The Pope Speaks*, *National Catholic Bioethics Quarterly* 9.2 (Summer 2009): 329, 331, doi: 10.5840/ncbq20099259.
[14] USCCB, *Ethical and Religious Directives*, no. 25.

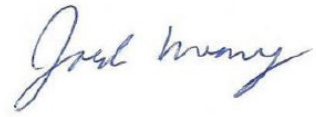
subsidiarity, according to which a higher-level social authority cannot take from a lower-level group those choices that its members are able to make.

*Health care team members must be authorized to exercise their professional judgment on whether a pronouncement of death should be made and on how death should be determined, in a specific situation for a specific patient, provided this meets all requirements of law, hospital policy, and medical standards for pronouncing death*. However, this does not mean the health care team can violate patient consent, conduct testing without consent when such testing may harm the patient (e.g., apnea test), or apply any techniques that are designed to cause or ensure brain death after declaration of circulatory death, such as extracorporeal interval support for organ retrieval with occlusion of blood vessels to the brain. The privilege and authority of the professional-patient relationship must be protected to ensure the patient's "dignity and essential place" in the practice of medicine. This relationship of solidarity, which is sensitive to the patient's dignity and, through subsidiarity, to his or her values and goals, is possible only among those in a healing relationship, not with a hospital or OPO, their administrators, or their policies. The public's trust in the medical community is based not only on the latter's technical expertise but perhaps even more so on the confidence that, when a person is seriously ill, he can enter an "interpersonal relationship" with an individual "who encounters him in order to support and care for him, thus adopting a sincere attitude of 'compassion.'"[15]

Maintaining trust in the organ/tissue transplantation process, especially regarding the pronouncement of death, will be impossible without first demonstrating respect for the sanctity of each human life, which may not be superseded by either the benefits to society of contemporary organ/tissue transplantation or the clinical, technological, and organizational demands of transplantation programs. The principles of dignity, solidarity, and subsidiarity—which originate in the natural law and are knowable by reason, irrespective of a person's values—make an indispensable contribution to this work. At stake is whether vulnerable patients may be compromised in the process of procuring vital organs to save the lives of others.

[15] Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, English ed., trans. The National Catholic Bioethics Center (Philadelphia: National Catholic Bioethics Center, 2017), no. 4.

Joseph Meaney, PhD



President

The National Catholic Bioethics Center

600 Reed Road, Suite 102

Broomall, PA 19008

215-877-2770

Leo Zanchettin

Chair, Board of Directors

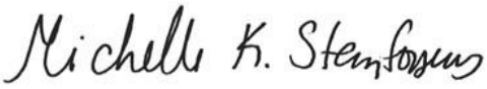
The National Catholic Partnership on Disability

415 Michigan Avenue, NE, Suite 95

Washington, DC, 20017

771-203-4477

Michelle K. Stanford, MD



President

The Catholic Medical Association

550 Pinetown Road, Suite 205

Fort Washington, PA 19034

484-270-8002