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A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

Also in this issue: “Global Ischemic Penumbra and Brain Death,” by Christina Leblang

Principles of an Option for the Poor in Bioethics

Christopher Reilly

In 1971 following declarations about poverty at meetings of the Latin American bishops, Pope St. Paul VI wrote in his pastoral letter *Octogesima adveniens* that “in teaching us charity, the gospel instructs us in the preferential respect due to the poor and the special situation they have in society: the more fortunate should renounce some of their rights so as to place their goods more generously at the service of others.”[1] Some fifty years later, Pope Francis also declared that without the preferential option for the poor, “the proclamation of the Gospel … risks being misunderstood or submerged.”[2] The preferential option for the poor, its potential as a guiding concept, and the ambiguities related to it are reviewed in detail in the current issue of the *National Catholic Bioethics Quarterly*.[3] Here, we focus on proposals for use and elaboration of the concept in bioethics. Aside from the desire to extend charity to the poor, how can we define this concept? What are the personal, ideological, and theological implications of applying it in analyses of social concerns?

The principles that follow should in no way be construed as relying on an assumption that there exists an immanent or structurally determined opposition between classes. Neither should these principles be taken as advocating the appropriation of concepts and assumptions advanced by Marxist or other critical theories, particularly those that suggest a permanence of discrimination and antagonism between racial groups, or any other groups in society, or which impose a paternalistic standard without regard to individual needs. Rather, the central message of the preferential option is one of Christian love, which is self-giving and respectful of the dignity of others.[4] While this may include a variance in financial requirements for individuals in health care, every patient is due all the rights of self-determination and devoted care regardless of economic status. In social reform, particularly in health systems, the value and virtue to be pursued is solidarity.[5]

We Must Recognize Christ in the Oppressed Person. Christ’s example, expressed in the Beatitudes, and his command of love for our neighbor call for giving preference, in thought and action, to raising up those who suffer materially and spiritually. It is crucial to understand that this is a matter not solely of charity but of recognizing Christ in the oppressed person; our treatment of the poor has a profound spiritual significance: “For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me” (Matt. 25:35).

Health Care Institutions Share the Obligations of the Wealthy. There is not only a demand for mercy on the part of the poor sufferer but also an obligation, challenge, and hazard that comes with the possession of wealth. The Gospel according to Luke, especially, presents Jesus’s dramatic illustrations of this obligation to share one’s wealth in the parable of the rich man and Lazarus: “Between us and you a great chasm has been fixed, in order that those who would pass from here to you may not be able, and none may cross from there to us” (Luke 16:26).[6] In bioethics we might also consider that health care institutions can be counted among the privileged, and the staff and medical personnel of such institutions have a consequent obligation to orient their institutions’ policies toward justice for the poor.[7] For example, are Catholic medical institutions complicit in residential racial segregation and black community disinvestment?[8] Should those involved in public medicine and health policies structure health systems and related payment configurations to impose and enforce a disproportionate burden on the wealthy?

Poverty Is Not an Essential Characteristic of Persons. Poverty is an oppressive condition that can be identified by its effects, including loss of, or threats to, health. It is not, however, merely (or primarily) a social category, but a condition personally experienced by individuals in the most intimate way.[9] The preferential option for the poor is, therefore, in its most fundamental expression attention to the living dignity of real children of God. The preferential option provides an enhanced motivation for beneficence that goes far beyond merely contractual or reciprocal notions of interpersonal obligations among human beings, including the rights of patients.

The Primary Social Relation Emphasized in the Preferential Option Is the Relation between Loving Christians and the Poor. It is not, that is, the relation between the powerful and those they might oppress, intentionally or not.[10] The advocates and practitioners of the preferential option, therefore, do not essentially (necessarily) take an antagonistic stance toward the wealthy or a revolutionary attitude to social structures. Rather, they seek justice, reform, and sustained conditions that lift up the poor. In bioethics the priority will be to improve the health and conditions of the patient, not necessarily or primarily to impose structures of utilitarian or reciprocal equity and fairness on society at large.[11] The US Catholic bishops chastised those who champion the option for the poor yet also “seem to ignore the centrality of family, the emphasis on economic initiative, and the warnings against the bureaucratic excesses of a ‘social assistance’ state. Our social tradition is a moral framework, not a partisan platform or ideological tool.”[12]

The Poor Carry an Epistemic Privilege in Understanding the Nature of Poverty. As such, they can provide vital input on possibilities for health care reform, especially because of their intensely personal experience of poverty and its spiritual and material effects, their perspective on the presence and operations of systems of oppression, and their lived experience of suffering. The poor's understanding of the meaningfulness of suffering in a spiritually justified life and their affinity with the suffering and humiliation of Christ provide hermeneutic insight and valuable testimony for the Christian experience of the whole community. We might also avoid the technocratic and bureaucratic practice of medicine that fails to respect the personal dignity of individual concerns, the more affective components of rational decision-making, and the primacy of familial and communal relations between patients and others they are close to. Respect for individual, family, and local culture is encouraged by the Church's consistent teaching on the principle of subsidiarity that "generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need."[13]

Justice for the Poor Cannot be Accomplished without Actual Reform. Justice, which is a matter of giving each person his or her due (*Catechism*, n. 1807), cannot be accomplished without reform of economic, political, and cultural structures—including health care structures—that may have a real effect of bias against the welfare and communal participation of the poor. These may include national health systems, policies regarding medical research and practice, legal regimes, and health care institutions. On the other hand, Paul VI taught that "the best structures and the most idealized systems soon become inhuman if the inhuman inclinations of the human heart are not made wholesome, if those who live in these structures or who rule them do not undergo a conversion of heart and of outlook."[14]

Love of God and Neighbor Is the Greatest Ideology. Discrimination against the poor is often encouraged by various habitual means of categorizing personal identities, culturally dominant or hidden structures of interpersonal behavior, and ideologies that merge ideas, arguments, and interests in persistent conceptual unities that are given force by material institutions. People can be educated to recognize and alter such cultural behaviors and thoughts. In bioethics scholarship and practice, we can do more to understand and explain how love of God and neighbor is the greatest ideology, one that has a rich history of concepts available in Christian moral theology, particularly through reflection on the Beatitudes and analysis of the virtues.

Poverty Is a Condition of Living that Intersects with Multiple Characteristics of Persons. These characteristics include race, ethnicity, gender, health status, marital status, and so on. Investigation of social and structural discrimination against certain personal characteristics must therefore be integrated into any analysis of poverty and the policies needed to alleviate it. For example, how is the eugenic application of genetic tests for embryo selection motivated by perceived economic or occupational privileges for selected children, and will such practices by the wealthy result in a genomic divide between the descendants of the rich and poor populations? How will various fiscal policies or health care structures aimed at reducing racial discrimination affect the rate of abortion among the poor?

Individual Testimony Has the Power to Provide Understanding. Loving acts are typically accompanied and enhanced by passion, and perhaps the insights into intersectionality and the hermeneutic privilege of the oppressed, described by authors oriented by the preferential option as well as critical race theory, can be highlighted more vividly in bioethical scholarship and communications. The narrative approach to bioethics (also "narrative inquiry" or "narrative based medicine") has for a while demonstrated the power of individual testimony to provide understanding of the complexity of health care experiences and to encourage empathy among providers and other stakeholders. Christian bioethicists can offer significant value by gathering, studying, and relating such testimony of how our society's poorest members struggle for medical assistance. We can provide further value by sharing our love and respect in person with those who graciously share their stories.

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Endnotes

1. Paul VI, *Octogesima adveniens* (May 14, 1971), n. 23.
2. Francis, *Evangelii gaudium* (November 24, 2013), n. 199, citing John Paul II, *Novo millenio ineunte* (January 6, 2001), n. 53.
3. Christopher M. Reilly, "Preferential Option for the Poor and Critical Race Theory in Bioethics," *The National Catholic Bioethics Quarterly* 21.4 (Winter 2021): 647–665.
4. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013).
5. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018), dir. 23, part 1 intro; John Paul II, *Sollicitudo rei socialis* (December 30, 1987), n. 43; and National Conference of Catholic Bishops, *Economic Justice for All* (Washington, DC: NCCB, 1986), n. 80.
6. This is a recurrent theme in the Bible. See Matt. 6:19–21; Prov. 23:5; Luke 16:13; and 1 Tim. 6:10.
7. USCCB, *Ethical and Religious Directives*, dir. 9.
8. Cory D. Mitchell and M. Therese Lysaught, "Equally Strange Fruit: Catholic Health Care and the Appropriation of Residential Segregation," *Journal of Moral Theology* 8.1 (2019): 36–62.
9. For some discussion of this topic, see Caterina Ruggeri Laderchi et al., "Does It Matter That We Do Not Agree on the Definition of Poverty? A Comparison of Four Approaches," *Oxford Development Studies* 31.3 (September 2003): 243–274, doi: 10.1080/1360081032000111698; David Piachaud, "Problems in the Definition and Measurement of Poverty," *Journal of Social Policy* 16.2 (April 1987): 147–164, doi: 10.1017/S0047279400020353; and Robert Haveman, "Who Are the Nation's 'Truly Poor'? Problems and Pitfalls in (Re)defining and Measuring Poverty," *Brookings Review* 11.1 (Winter 1993): 24–27, doi: 10.2307/20080360.
10. For a biblical foundation for this principle, see Jesus's and the Apostles' attitudes toward the powerful and the state in 1 Tim. 2:1–15, Mark 12:17, Rom. 13:1–7, Heb. 13:17, and 1 Peter 2:13–15.
11. The preferential option for the poor is certainly relevant in considerations of the nature of the welfare state, health care laws, medical industry and marketing, and so on. See *Poverty Is a Condition of Living that Intersects with Multiple Characteristics of Persons*: The point being made here is that the priority is the relief of poverty and its effects rather than competition over political rights or insistence on structures of equity and fairness.
12. National Conference of Catholic Bishops, *A Decade after "Economic Justice for All"* (Washington, DC: NCCB, 1995), n. 3.
13. Benedict XVI, *Deus caritas est* (December 25, 2005), n. 18.
14. Paul VI, *Evangelii nuntiandi* (December 8, 1975), n. 36.

Global Ischemic Penumbra and Brain Death Declaration

Christina Leblang

Organ donation is a beautiful practice and supreme act of charity for another individual.[1] It would be a travesty to lose the practice of organ donation. However, it is difficult in certain circumstances to truly discern when someone is brain dead and able to gift their organs to another.[2] While there may never be absolute certitude in identifying someone who is brain dead, there must at least be moral certitude (i.e., prudential certitude).[3] This can be complicated by greater ambiguity in certain conditions, such as global ischemic penumbra.

Consider the case of Jahi McMath, a thirteen-year-old girl from California who was declared brain dead in 2013. Jahi suffered from sleep apnea and was admitted to Oakland's Children's Hospital for what was supposed to be routine surgery to remove her tonsils. Hours after surgery, she hemorrhaged, and her heart stopped. Her medical team was able to get her heart beating again but after two days declared that she was brain dead, according to the accepted guidelines: "Her pupils did not react to light, she did not have a gag reflex, and her eyes remained still when ice water was dripped in each ear. She was briefly disconnected from the ventilator, as a test, but her lungs filled with carbon dioxide. On an EEG test, no brain-wave activity could be seen."[4]

Yet, Jahi's family did not believe she was dead. They did not want the ventilator disconnected nor did they want to consider organ donation. After turning to legal recourse, a second examination of brain death was conducted by Paul Fisher, chief of child neurology at Stanford University's children's hospital. He declared Jahi brain dead. Jahi's family still did not agree and was able to have her transported to a New Jersey hospital and eventually to an apartment with her family. Jahi died approximately four years later.

During the years between Jahi's first death certificate and her passing, Jahi showed directed responses to family members and nurses. *The New Yorker* explains that her heart rate would slow when the music therapist visited and played calming music, and that Jahi was able to move the correct body part after being asked to do so. Jahi even started her menstrual cycles. This evidence seems to indicate that Jahi was not dead. Although whole brain death does not mean that every single neuron in the brain is dead, it does mean that the majority of the brain has died such that its ability to function as the integrating organ has ceased. Calixto Machado, the president of the Cuban Society of Clinical Neurophysiology, reviewed MRI scans taken months after Jahi's initial brain death declaration. He noted that rather than a liquefied brain (which one would anticipate if she really was brain dead), "large areas of her cerebrum, which mediates consciousness, language, and voluntary movements, were structurally intact."[5]

Dr. Alan Shewmon argues that Jahi did in fact meet the necessary criteria to be declared brain dead while in fact she was not. He claims, rather, that she suffered from a case of global ischemic penumbra. This claim is not insubstantial, because distinguishing this condition from brain death is not currently possible when following American Academy of Neurology guidelines. As such, proper adherence to guidelines and standards and full documentation would not have prevented this scenario or the repeat of others like it.[6] In fact, had Jahi's family not sought other medical care and demanded that she be moved, had they instead followed the advice of Jahi's original doctors and even gone so far as to acquiesce to organ donation, their daughter would not have died naturally but rather would have been killed by doctors as they removed her organs from her body. While moral certitude rather than absolute certainty is all that we can strive for, the awareness of this case casts doubt on moral certitude and thus requires further analysis and review.

Global Ischemic Penumbra

Ischemic penumbra refers to the "region of reduced CBF [cerebral blood flow] with absent spontaneous or induced electrical potentials that still maintained ionic homeostasis and transmembrane electrical potentials."[7] In other words, in the case of a patient who has suffered a stroke, the ischemic penumbra is that part of the brain in which the neurons are not firing properly due to lack of blood flow but also a region in which the brain tissue can be restored, albeit perhaps not fully. In the case of global ischemic penumbra (GIP), then, we are considering the brain as a whole, as opposed to a portion of the brain.[8]

Many cases of whole brain death happen when pressure inside the brain increases causing a lack of blood flow to the brain and the subsequent death of the brain (i.e., the death of the person). While this is what appears to happen, Coimbra claims that this may not actually happen in all instances of declared whole brain death. He bases this claim on two key points:

1. It has been noted that with other tissues, a "sustained absence of the specialized cellular functions" does not equate to either irreversible damage or cell death.
2. "Under incomplete ischemic conditions (BBF between 10.0 and 35.0 ml/100g-min) suppressed neurological functions remain recoverable by recirculation for up to 48 hours."[9]

In other words, if a person suffers from GIP, the brain cells may not be perfused at a level to allow for all normal brain functions to continue. Yet, perfusion remains high enough that the brain tissue can recover at least some of its functioning once the perfusion rate is increased.

When determining whether someone is brain dead, the clinician applies a series of tests to look for responses to stimuli that indicate functioning of the brain. These include pupil and facial responses to various stimuli along with gag and coughing reflexes. These primarily clinical tests let the clinician know if someone is brain dead or just neurologically impaired. Brain death is accepted as actual death by both the medical field and by the Catholic Church.[10] Someone who is dead no longer needs a respirator or other medical interventions unless attempting to preserve his or her organs for donation. With the determination of death, one can remove all medical interventions and allow the body to undergo the process of decay. However, since global ischemic penumbra results in the same depressed reflexes as brain death but is in reality a severe neurological impairment, it is reasonable to conclude that the current clinical criteria may in fact diagnose someone as brain dead who actually suffers from GIP.

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Human Dignity and Respect for Life

Clinicians must take extreme care in determining whether a patient is dead as opposed to severely comatose. First and foremost, "Clinicians must be able to establish the proximate cause of a patient's coma and that it is irreversible"[11] rather than a reversible coma (which may happen, for example, from a drug overdose or hypothermia). Given complications and the potential for misdiagnosis, the American College of Medical Toxicology has gone so far as to recommend that "clinical determination of brain death should only be made in the absence of drug intoxication or poisoning."[12]

While it is never permissible to cause the death of one individual to save the life of another, it is important to recognize that there are potentially multiple lives at stake in the moral analysis of this very difficult situation. Putting organ transplantation on hold for a small period of time has the potential to impact the lives of thousands of individuals. Over 33,000 organ donations were performed in 2020 from deceased individuals.[13] (Of course some of these individuals died from cardiorespiratory failure rather than brain death.) These numbers are not given in order to perform a utilitarian calculus, but to more deeply recognize the great impact a call to pause organ donation really is. Secondly, it is important to remember those individuals who are in fact brain dead (and their families). Brain dead individuals may be kept on medical interventions with their organs functioning for some time. While presumably rare, it could cause great anguish and financial burden for a family who does not know if their loved one is alive or dead.

In the end, the analysis comes down to whether the potential that patients are suffering undiagnosed GIB provides enough doubt to warrant reconsideration of current guidelines in determining brain death. Given the immeasurable worth of every life and the intrinsically evil nature of an act of killing, it would be appropriate to suspend declarations of brain death and organ procurement until greater certitude can be reached about the diagnosis and evaluation of a person who appears to be brain dead but rather suffers from GIP.

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Notes

1. Pius XII, *Allocution to Eye Specialists*, (May 14, 1956). Pius calls organ donation an act of "merciful charity shown to some suffering brothers and sisters;" see also, Catechism of the Catholic Church, 2nd ed. (Washington, DC: United States Conference of Catholic Bishops/Libereria Editrice Vaticana, 2016 update), n. 2296.
2. For more on the debate surrounding brain death, see Melissa Moschella, "Brain Death and Human Organismal Integration: A Symposium on the Definition of Death," *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 41.3, (June 2016): 229–236; and Charles Camosy, *Losing Our Dignity: How Secularized Medicine is Undermining Fundamental Human Equality* (Hyde Park, NY: New City Press, 2021).
3. John Haas, "Prudence in St. Thomas Aquinas: Certitude in Ambiguity," in *Ambiguity in the Western Mind*, ed. Craig J.N. de Paulo, Patrick Messina, and Marc Stier (New York: Peter Lang Publishing, 2005), 105–106.
4. Rachel Aviv, "What Does it Mean to Die?" The New Yorker, February 5, 2008, https://www.newyorker.com/magazine/2018/02/05/what-does-it-mean-to-die (accessed December 14, 2021).
5. Aviv, "What Does it Mean to Die?"
6. Matthew Hanley, *Determining Death by Neurological Criteria* (Philadelphia, PA: The National Catholic Bioethics Center/Catholic University of America Press, 2020). One area of great concern is the proper adherence to guidelines and standards and full documentation. Hanley details numerous instances of lack of documentation and procedural consistency within the United States and internationally. Many claim that misdiagnosis is due to these inconsistencies rather than a problem with the guidelines.
7. Jens Astrup et al., "Thresholds in Cerebral Ischemia—the Ischemic Penumbra," *Stroke* 12 (November 1981): 723–725, doi: 10.1161/01.str.12.6.723.
8. C. G. Coimbra, "Implications of Ischemic Penumbra for the Diagnosis of Brain Death," *Brazilian Journal of Medicine and Biological Research* 32.12 (December 1999): 1479–1487.
9. Coimbra, "Implications of Ischemic Penumbra," 1480.
10. Pontifical Academy of Sciences, "Why the Concept of Death Is Valid as a Definition of Brain Death: Statement by the Pontifical Academy of Sciences and Response to Objections," in *The Signs of Death, the Proceedings of the Working Group of 11–12 September 2006* (Vatican City, 2007), 5–13.
11. Hanley, *Determining Death*, 18.
12. Mark J. Neavyn et al., "ACMT Position Statement: Determining Brain Death in Adults after Drug Overdose," *Journal of Medical Toxicology* 13.3 (September 2017): 271–273.
13. Organ Procurement and Transplantation Network, "Annual Record Trend Continues for Deceased Organ Donation, Deceased Donor Transplants," January 11, 2021, https://optn.transplant.hrsa.gov/news/annual-record-trend-continues-for-deceased-organ-donation-deceased-donor-transplants/ (accessed December 14, 2021).

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