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## EthxWeb Search Results

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**Article** Document 1

Feldt, Karen S; Bond, Gail E; Jacobson, Dana; Clymin, Janine

### **Washington State Death with Dignity Act: implications for long-term care.**

Journal of gerontological nursing 2011 Oct; 37(10): 32-40

**Abstract:** The Washington Death with Dignity Act (DWDA) allows competent, terminally ill adults to request a lethal dose of medication from a physician. The purpose of this study was to explore knowledge of Directors of Nursing (DONs) in long-term care (LTC) and assisted living facilities regarding the DWDA. Findings of the survey provide insight into DONs' understanding of the law and whether they have provided staff education regarding how to respond to resident requests. This survey, although limited by sample size, may provide guidance for policy development in LTC settings regarding similar laws.



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**Article** Document 2

Rodríguez-Arias, David; Smith, Maxwell J; Lazar, Neil M

### **Donation after circulatory death: burying the dead donor rule.**

The American journal of bioethics : AJOB 2011 Aug; 11(8): 36-43

**Abstract:** Despite continuing controversies regarding the vital status of both brain-dead donors and individuals who undergo donation after circulatory death (DCD), respecting the dead donor rule (DDR) remains the standard moral framework for organ procurement. The DDR increases organ supply without jeopardizing trust in transplantation systems, reassuring society that donors will not experience harm during organ procurement. While the assumption that individuals cannot be harmed once they are dead is reasonable in the case of brain-dead protocols, we argue that the DDR is not an acceptable strategy to protect donors from harm in DCD protocols. We propose a threefold alternative to justify organ procurement practices: (1) ensuring that donors are sufficiently protected from harm; (2) ensuring that they are respected through informed consent; and (3) ensuring that society is fully informed of the inherently debatable nature of any criterion to declare death.



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**Article** Document 3

Hester, D Micah; Green, Jerril

### **It's all about the brain.**

The American journal of bioethics : AJOB 2011 Aug; 11(8): 44-5



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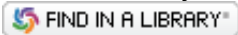


**Article** Document 4

DuBois, James M

**Dead tired of repetitious debates about death criteria.**

The American journal of bioethics : AJOB 2011 Aug; 11(8): 45-7



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**Article** Document 5

Chen, Yen-Yuan; Ko, Wen-Je

**Further deliberating burying the dead donor rule in donation after circulatory death.**

The American journal of bioethics : AJOB 2011 Aug; 11(8): 58-9



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**Article** Document 6

Napier, Stephen

**Out of the frying pan and into the fire.**

The American journal of bioethics : AJOB 2011 Aug; 11(8): 60-1



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**Article** Document 7

Gillett, Grant

**The death of a living soul.**

Journal of law and medicine 2011 Jun; 18(4): 695-700

**Abstract:** We are bedevilled with varying definitions of death, ranging from higher brain death to cardiovascular or somatic death. They all try to capture what is essential to our reasoning about the importance of human death. This column argues that what they all neglect is the Aristotelian inspiration of many of the attempts at reformulation of the definition. Aristotle's work on the soul focuses on the loving soul as the form of humanity that makes human living and dying the morally significant phenomenon that engages law-makers and ethicists alike. The form of humanity comprises a holistic package of properties which cannot be dealt with in a reductive manner and which our criteria for death must answer to. When that is clarified, the role of these criteria and their importance both become more transparent.



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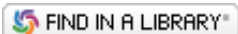


**Article** Document 8

Mizuguchi, M

**[Recent topics of children's brain death in Japan].**

No to hattatsu. Brain and development 2011 May; 43(3): 220-2



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**Article** Document 9

Burkle, Christopher M; Schipper, Agnes M; Wijdicks, Eelco F M

**Brain death and the courts.**

Neurology 2011 Mar 1; 76(9): 837-41

**Abstract:** Brain death determinations have been challenged in courts, but no systematic study has been published in the medical literature. Court cases on brain death determination could provide some insights for the clinical practice of physicians. We reviewed legal cases between 1980 and 2010 involving neurologic criteria for death since adoption

of the Uniform Determination of Death Act. Court rulings on brain death determination are uncommon, but 2 major themes emerged: consequences of documentation of the time of brain death and family-physician discord on withdrawal of intensive care support. All court rulings upheld the medical practice of death determination using neurologic criteria according to state law, irrespective of other elements of the rulings. Nothing in the court cases suggests a need to alter the current medical standard of brain death determination. Jurisprudence to date emphasizes that the timing and accurate diagnosis of brain death has important weight in the resolution of conflict between practitioners, hospitals, and family members.



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**Article** Document 10

Peltier, J W; D'Alessandro, A M; Hsu, M; Schibrowsky, J A

**A hierarchical communication model of the antecedents of health care professionals' support for donations after cardiac death.**

American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons 2011 Mar; 11(3): 591-8

**Abstract:** Using structural equation modeling, the direct and indirect impact of five variables on the support of donation after cardiac death from the perspective of health care professionals were investigated: knowledge, trust in the transplant team, whether patients are in a state of irreversibility, whether health care professionals participate in a patient's death, and perceptions about the brain death versus cardiac death donation process. In total, 10/15 relationships posited in the model had significant pathways. The results provide insight into sequential communication strategies for generating support for donations after cardiac death.



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**Article** Document 11

Bedir, Ahmet; Asksoy, Sahin

**Brain death revisited: it is not 'complete death' according to Islamic sources**

Journal of Medical Ethics 2011 February 2: 5 p. [Online].



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<http://jme.bmj.com/content/early/2011/02/02/jme.2010.040238.full.pdf> (link may be outdated)

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**Article** Document 12

Egea-Guerrero, Juan José; Revuelto-Rey, Jaume; Latronico, Nicola; Rasulo, Frank A; Wijdicks, Eelco F M

**The case against confirmatory tests for determining brain death in adults.**

Neurology 2011 Feb 1; 76(5): 489; author reply 489-90



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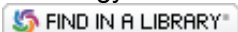


**Article** Document 13

Machado, Calixto; Pérez-Nellar, Jesús; Estevez, Mario; Gonzalez, Eli

**Evidence-based guideline update: Determining brain death in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology.**

Neurology 2011 Jan 18; 76(3): 307; author reply 308-9



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Article Document 14

Jeret, Joseph S

**Evidence-based guideline update: Determining brain death in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology.**

Neurology 2011 Jan 18; 76(3): 307-8; author reply 308-9



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Article Document 15

Lustbader, D; O'Hara, D; Wijdicks, E F M; MacLean, L; Tajik, W; Ying, A; Berg, E; Goldstein, M

**Second brain-death examination may negatively affect organ donation.**

Neurology 2011 Jan 11; 76(2): 119-24

**Abstract:** Little is known about the impact of the requirement for a second brain-death examination on organ donation. In New York State, 2 examinations 6 hours apart have been recommended by a Department of Health panel.



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Article Document 16

Martínez-Alarcón, L; Ríos, A; Sánchez, J; Guzmán, D; López-Navas, A; Ramis, G; Febrero, B; Ramírez, P; Parrilla, P

**Do future journalists have a favorable attitude toward deceased donation?**

Transplantation proceedings 2011 Jan-Feb; 43(1): 52-4

**Abstract:** The information provided by future journalists is fundamental for promoting healthcare and their attitude toward organ donation and transplantation (ODT) could affect public opinion. The objective of this study was to analyze the attitude of students of journalism toward ODT and the factors affecting this attitude.



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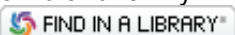
Article Document 17

Zielinski, Pamela B

**Brain death, the pediatric patient, and the nurse.**

Pediatric nursing 2011 Jan-Feb; 37(1): 17-21, 38; quiz 22

**Abstract:** The term "brain death" has ties to medical, legal, ethical, and philosophical discourse, and is therefore a complicated and potentially ambiguous term. Some state that with brain death a person no longer has a "master regulating" organ integrating his or her organism as a whole, and the proponents of this view equate this loss of integration with clinical death. Others believe this is not a tenable reason to deem an individual who is brain dead as clinically dead; thus, controversy exists surrounding this issue, and nurses are not resistant to this debate. Whether one supports the definition of brain death as clinical death or not appears to depend on one's view of the mind-body relationship. Pediatric nurses are involved in this controversy because of the care they provide to both the affected child and family in this troubling time.



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Article Document 18

Padela, Aasim I.; Shanawani, Hasan; Arozullah, Ahsan

**Medical experts and Islamic scholars deliberating over brain death: gaps in the applied Islamic bioethics discourse**

Muslim World 2011 January; 101(1): 53-72 [Online]. Accessed: <http://onlinelibrary.wiley.com/doi/10.1111/j.1478->



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Chapter Document 19

Padela, Aasim I.; Kholwadia, Mohammed Amin; Arozullah, Ahsan

**Brain death: ethico-legal and metaphysical challenges for modern Islamic bioethics**

In: Arda, Berna; Rispler-Chaim, Vardit, eds. Islam and Bioethics. Ankara [Turkey]: Ankara University; 2011: 131-149

Call number: [R725.59 .I85 2010](#)

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Chapter Document 20

Padela, Aasim I. Shanawani, Hasan; Arozullah, Ahsan

**Medical experts and Islamic scholars deliberating over brain death: gaps in the applied Islamic bioethics discourse**

In: Arda, Berna; Rispler-Chaim, Vardit, eds. Islam and Bioethics. Ankara [Turkey]: Ankara University; 2011: 55-75

Call number: [R725.59 .I85 2010](#)

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Article Document 21

Hills, Teresa E

**Determining brain death: a review of evidence-based guidelines.**

Nursing 2010 Dec; 40(12): 34-40; quiz 40-1



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Article Document 22

Verheijde, Joseph L.; Potts, Michael

**Commentary on the concept of brain death within the Catholic bioethical framework**

Christian Bioethics 2010 December; 16(3): 246-256



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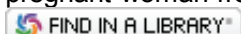
Article Document 23

Gregorian, Alexis

**Post-mortem pregnancy: a proposed methodology for the resolution of conflicts over whether a brain dead pregnant woman should be maintained on life-sustaining treatment.**

Annals of health law / Loyola University Chicago, School of Law, Institute for Health Law 2010 Winter; 19(2): 401-24, preceding i

**Abstract:** In this article, the author examines conflicts over whether to maintain a brain dead pregnant woman on life-sustaining treatment. The author cautions that on the rare occasions when courts are confronted with such a conflict, they should employ a consistent methodology for resolution of the conflict and attempt to honor the wishes of the post-mortem mother and her family. The author draws on relevant areas of law to demonstrate the existence of a legal fiction that protects the interests of post-mortem pregnant women in refusing medical treatment. This article then proceeds to propose a methodology that enables courts to account for a post-mortem pregnant woman's interests, her family's interests, and the state's interests in resolving conflicts over whether to remove a post-mortem pregnant woman from life-sustaining treatment.



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Article Document 24

Aruga, Tohru

**[Organ transplantation from the brain dead in Japan. Preface].**

Nippon rinsho. Japanese journal of clinical medicine 2010 Dec; 68(12): 2161-3



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Article Document 25

Machino, Saku

**[Brain death and death of human individual].**

Nippon rinsho. Japanese journal of clinical medicine 2010 Dec; 68(12): 2215-20

**Abstract:** The revised Organ Transplant Law of Japan, enforced from July, 2010, has made "brain death", as well as "cardiac death", death of human individual and procurement of an organ from a brain dead body is now possible by a surviving family's consent. However, brain death issue is a still serious topic, and arguments are going around on whether it is morally justifiable to accept brain death, and if so, in what sense. The author argues that death of human being occurs when "vital triangle," consisted of brain, heart and lung, is severed out.



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Article Document 26

Akiba, Etsuko

**[Japanese ethos and organ transplantation from brain-dead donors].**

Nippon rinsho. Japanese journal of clinical medicine 2010 Dec; 68(12): 2234-8

**Abstract:** A trend observed since the 1980s in the Japanese academic scene is the overturning of Hippocratic ethics by American individualistic bioethics. However, the Japanese ethos is more sympathetic to personalistic bioethics rooted in Hippocratic ethics, which assumes the universal view of the 'interdependent self' clearly marked off from the 'independent self' specific to American culture. In Japan, organ transplantation from brain-dead donors is promoted despite the lack of consensus on whether brain death signifies death of the individual. From the viewpoint of personalistic bioethics, this situation is problematic because it violates the dictum primum non nocere of the Hippocratic Oath. We should therefore first establish consensus on brain death and then promote a 'culture of donation' based on human dignity.



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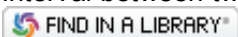
Article Document 27

Mizuguchi, Masashi

**[Diagnostic criteria of brain death for Japanese children].**

Nippon rinsho. Japanese journal of clinical medicine 2010 Dec; 68(12): 2317-21

**Abstract:** In Japan, a revised act on organ transplantation is enforced from July 2010. This act enables an infant or a child with brain death to become a donor for organ transplantation under the consent of his or her family members. New diagnostic criteria have been set for children under six years of age. Diagnosis of brain death in infancy and childhood requires special caution, since an infant's brain has special features. The causes of brain death also vary according to the age. The new criteria exclude from candidates of donor neonates and infants under 12 weeks of corrected age, as well as cases in which the possibility of child abuse cannot be completely denied. The time interval between two diagnostic procedures must be 24 hours or more.



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Article Document 28

Miller, Franklin G; Truog, Robert D

**Decapitation and the definition of death.**

Journal of medical ethics 2010 Oct; 36(10): 632-4

**Abstract:** Although established in the law and current practice, the determination of death according to neurological criteria continues to be controversial. Some scholars have advocated return to the traditional circulatory and respiratory criteria for determining death because individuals diagnosed as 'brain dead' display an extensive range of integrated biological functioning with the aid of mechanical ventilation. Others have attempted to refute this stance by appealing to the analogy between decapitation and brain death. Since a decapitated animal is obviously dead, and 'brain death' represents physiological decapitation, brain dead individuals must be dead. In this article we refute this 'decapitation gambit.' We argue that decapitated animals are not necessarily dead, and that, moreover, the analogy between decapitation and the clinical syndrome of brain death is flawed.



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**Article** Document 29

Antommara, Armand H Matheny

**Conceptual and ethical issues in the declaration of death.**

Pediatrics in review / American Academy of Pediatrics 2010 Oct; 31(10): 427-30



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**Article** Document 30

Tonti-Filippini, Nicholas

**Secularism and loss of consensus about the diagnosis of death**

The National Catholic Bioethics Quarterly 2010 Autumn; 10(3): 491-514



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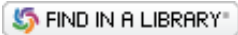


**Article** Document 31

Delmonico, Francis L.

**The concept of death and deceased organ donation**

The National Catholic Bioethics Quarterly 2010 Autumn; 10(3): 451-458



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**Article** Document 32

Fry-Revere, Sigrid; Reher, Thomas; Ray, Matthew

**Death: a new legal perspective.**

The Journal of contemporary health law and policy 2010 Fall; 27(1): 1-75



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**Article** Document 33

Nair-Collins, Mike

**Death, brain death, and the limits of science: why the whole-brain concept of death is a flawed public policy.**

The Journal of law, medicine & ethics : a journal of the American Society of Law, Medicine & Ethics 2010 Sep; 38(3): 667-83

**Abstract:** Legally defining "death" in terms of brain death unacceptably obscures a value judgment that not all



reasonable people would accept. This is disingenuous, and it results in serious moral flaws in the medical practices surrounding organ donation. Public policy that relies on the whole-brain concept of death is therefore morally flawed and in need of revision.



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**Article** Document 34

Henig, Robin Marantz

**When does life belong to the living?**

Scientific American 2010 Sep; 303(3): 50-4



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**Article** Document 35

Liao, Solomon; Ito, Shiho

**Brain death: ethical challenges to palliative care concepts of family care.**

Journal of pain and symptom management 2010 Aug; 40(2): 309-13

**Abstract:** Brain death is a controversial issue that is often difficult for families to understand or accept. Palliative care interventions can help families to accept the death. However, delaying pronouncement of brain death may be detrimental to the family and lead to financial, ethical, and legal complications, including the potential for insurance fraud. We describe a case of brain death in which the passage of time along with continuation of life support without concomitant testing for brain death led to decreased acceptance of the patient's death by the family. Clinicians should weigh the risks and benefits of harm to the family when deciding how long to keep a brain dead patient on a ventilator. Pronouncement of death, which is good basic medical care regardless of the cause or mechanism of death, should not be delayed for family considerations. Risk management should be involved early in the decision process, if life support is withdrawn without the family's assent.



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**Article** Document 36

Rady, Mohamed Y; Verheijde, Joseph L

**Lazarus phenomenon, autoresuscitation, and nonheart-beating organ donation.**

Critical care medicine 2010 Aug ; 38(8): 1757-8; author reply 1758-9



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**Article** Document 37

Zamperetti, Nereo

**Defining death in donation after circulatory determination of death protocols: a bluish shade of violet.**

Critical care medicine 2010 Aug ; 38(8): 1761; author reply 1761-2



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**Article** Document 38

Bernat, James L

**Point: are donors after circulatory death really dead, and does it matter? Yes and yes.**

Chest 2010 Jul ; 138(1): 13-6





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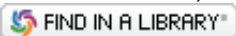


Article Document 39

Truog, Robert D; Miller, Franklin G

**Counterpoint: are donors after circulatory death really dead, and does it matter? No and not really.**

Chest 2010 Jul ; 138(1): 16-8; discussion 18-9



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Article Document 40

Nagahiro, Shinji

**[Revised act on organ transplantation from neurosurgeon's viewpoint]**

Brain and nerve = Shinkei kenkyu no shinpo 2010 Jun ; 62(6): 575-81

**Abstract:** The revised act on organ transplantation was passed in July 2009; it will be implemented in July 2010. This law allows organ donation from a brain-dead person with or without an Organ Donation Decision Card, if the family members permit this donation and the brain-dead person had not decided against it when conscious. In Japan, the legal definition of human death has not changed after the revision of the act on organ transplantation; therefore, brain death is considered human death for the purpose of organ transplantation. Certain minor revisions are required in the medical and legal criteria for diagnosis of brain death, especially for children under 6 years. Ancillary tests, including radioisotope measurement of cerebral blood flow and auditory brainstem evoked potentials, should be considered for younger children or in cases where comprehensive neurological examination was not possible because of injuries to the face, eyes, or ears. An increase in the number of organ donations from brain-dead persons because of the revised act will greatly increase the responsibility of and burden on hospitals and neurosurgeons that treat many emergency cases of severe brain injury and stroke. Adequate socioeconomic and systemic medical support should be provided to hospitals where organ donation is carried out.



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Article Document 41

Terayama, Yasuo

**[Revised act on organ transplantation from the neurological viewpoint]**

Brain and nerve = Shinkei kenkyu no shinpo 2010 Jun ; 62(6): 583-6

**Abstract:** A key purpose of the revised act on organ transplantation is to accept brain death as a person's death in a generic sense for the purpose of increasing the number of organ transplants from brain-dead donors, allowing priority organ donation to relatives, and allowing organ transplants from children aged 15 years or older and a person of any age with the approval of family members. Since the current law, enacted in June 1997, was implemented in October 1997, far fewer organs, including hearts, livers, and kidneys, have been transplanted in Japan than the corresponding number of organs transplanted abroad. This situation is also caused by a lack of the knowledge regarding brain death among neurologists as well as a lack of skill among those who are in charge of the determination of brain death. In Japan, there is no general consensus on whether brain death should be accepted as a person's death; however, there are people who require organ transplants. Understanding the standards of brain death determination and its neurological background may soon be mandatory for all neurologists.



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Article Document 42

Mizuguchi, Masashi

**[Revised act on organ transplantation: a pediatrician's viewpoint]**

Brain and nerve = Shinkei kenkyu no shinpo 2010 Jun ; 62(6): 587-94

**Abstract:** In Japan, from July 2010, an infant or a child with brain death will be legally regarded as a candidate of donor for organ transplantation under the consent of his or her family members. Official diagnostic criteria of brain

death in children are currently under compilation. The causes and incidence of brain death remarkably differ among individuals belonging to different age groups. Secondary brain damages resulting from asphyxia, drowning, hypoxemia, and cardiopulmonary arrest more commonly occur in childhood than in adulthood. Child abuse or neglect is suspected to be involved in many of the cases of brain death. The current Japanese diagnostic criteria hitherto used for adults require several modifications before these can be applied to infants and children. According to the requirements of the new act, abused or neglected infants and children must be excluded from the category of donor candidates. Neonates and young infants below 12 weeks of corrected age will also be excluded, because neurological diagnosis of brain death is difficult in these individuals.



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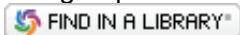
\*  Article Document 43

Veatch, Robert M

**Transplanting hearts after death measured by cardiac criteria: the challenge to the dead donor rule.**

Journal of Medicine and Philosophy 2010 June; 35(3): 313-329

**Abstract:** The current definition of death used for donation after cardiac death relies on a determination of the irreversible cessation of the cardiac function. Although this criterion can be compatible with transplantation of most organs, it is not compatible with heart transplantation since heart transplants by definition involve the resuscitation of the supposedly "irreversibly" stopped heart. Subsequently, the definition of "irreversible" has been altered so as to permit heart transplantation in some circumstances, but this is unsatisfactory. There are three available strategies for solving this "irreversibility problem": altering the definition of death so as to rely on circulatory irreversibility, rather than cardiac; defining death strictly on the basis of brain death (either whole-brain or more pragmatically some higher brain criteria); or redefining death in traditional terms and simultaneously legalizing some limited instances of medical killing to procure viable hearts. The first two strategies are the most ethically justifiable and practical.



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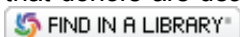
\*  Article Document 44

Miller, Franklin G.; Truog, Robert D.; Brock, Dan W.

**The dead donor rule: can it withstand critical scrutiny?**

Journal of Medicine and Philosophy 2010 June; 35(3): 299-312

**Abstract:** Transplantation of vital organs has been premised ethically and legally on "the dead donor rule" (DDR)-the requirement that donors are determined to be dead before these organs are procured. Nevertheless, scholars have argued cogently that donors of vital organs, including those diagnosed as "brain dead" and those declared dead according to cardiopulmonary criteria, are not in fact dead at the time that vital organs are being procured. In this article, we challenge the normative rationale for the DDR by rejecting the underlying premise that it is necessarily wrong for physicians to cause the death of patients and the claim that abandoning this rule would exploit vulnerable patients. We contend that it is ethical to procure vital organs from living patients sustained on life support prior to treatment withdrawal, provided that there is valid consent for both withdrawing treatment and organ donation. However, the conservatism of medical ethics and practical concerns make it doubtful that the DDR will be abandoned in the near future. This leaves the current practice of organ transplantation based on the "moral fiction" that donors are dead when vital organs are procured.



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\*  Article Document 45

Dubois, James M.

**The ethics of creating and responding to doubts about death criteria.**

Journal of Medicine and Philosophy 2010 June; 35(3): 365-380

**Abstract:** Expressing doubts about death criteria can serve healthy purposes, but can also cause a number of harms, including decreased organ donation rates and distress for donor families and health care staff. This paper explores the various causes of doubts about death criteria-including religious beliefs, misinformation, mistrust, and intellectual questions-and recommends responses to each of these. Some recommended responses are relatively simple and noncontroversial, such as providing accurate information. However, other responses would require significant changes to the way we currently do business. Policymakers should establish minimum national standards for determining death to foster a trustworthy system; academics and publishers have a duty to publish only materials that substantially engage and advance the debate to minimize the harm caused by divided expert opinion; and opposition to the dead donor rule should be conceptually separated from doubts about death criteria.



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\*  Article Document 46

Bernat, James L.

**How the distinction between "irreversible" and "permanent" illuminates circulatory-respiratory death determination.**

Journal of Medicine and Philosophy 2010 June; 35(3): 242-255

**Abstract:** The distinction between the "permanent" (will not reverse) and "irreversible" (cannot reverse) cessation of functions is critical to understand the meaning of a determination of death using circulatory-respiratory tests. Physicians determining death test only for the permanent cessation of circulation and respiration because they know that irreversible cessation follows rapidly and inevitably once circulation no longer will restore itself spontaneously and will not be restored medically. Although most statutes of death stipulate irreversible cessation of circulatory and respiratory functions, the accepted medical standard is their permanent cessation because permanence is a perfect surrogate indicator for irreversibility, and using it permits a more timely declaration. Therefore, patients properly declared dead in donation after circulatory death (DCD) protocols satisfy the requirements of death statutes and do not violate the dead donor rule. The acronym DCD should represent organ "donation after circulatory death" to clarify that the death standard is the permanent cessation of circulation, not heartbeat. Heart donation in DCD does not retroactively negate the donor's death determination because circulation has ceased permanently.



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\*  Article Document 47

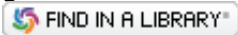
Shewmon, D. Alan

**Constructing the death elephant: a synthetic paradigm shift for the definition, criteria, and tests for death.**

Journal of Medicine and Philosophy 2010 June; 35(3): 256-298

**Abstract:** In debates about criteria for human death, several camps have emerged, the main two focusing on either loss of the "organism as a whole" (the mainstream view) or loss of consciousness or "personhood." Controversies also rage over the proper definition of "irreversible" in criteria for death. The situation is reminiscent of the proverbial blind men palpating an elephant; each describes the creature according to the part he can touch. Similarly, each camp grasps some aspect of the complex reality of death. The personhood camp, in contrast to the mainstream "organism" camp, recognizes that a human organism can still be a biological living whole even without brain function. The mainstream camp, in contrast to the personhood camp, recognizes that a person can be permanently, even irreversibly unconscious, and still be a living person so long as his/her body is alive. The author proposes that hylomorphic dualism incorporates both these key insights. But to complete the picture of the entire "death elephant," a fundamental paradigm shift is needed to make sense of other seemingly conflicting insights. The author proposes a "semantic bisection" of the concept of death, analogous to the traditional distinction at the beginning of life between "conception" and "birth." To avoid the semantic baggage associated with the term "death," the two new death-related concepts are referred to as "passing away" (or "deceased") and "deanimation," corresponding, respectively, to sociological ceasing-to-be (mirror image of birth) and ontological/theological ceasing-to-be of the bodily organism (mirror image of conception). Regarding criteria, the distinguishing feature is whether the cessation of function is permanent (passing away) or irreversible (deanimation). If the "dead donor rule" were renamed the "deceased donor rule" (both acronyms felicitously being "DDR"), the ethics of organ transplantation from non-heart-

beating donors could, in principle, be validly governed by the DDR, even though the donors are not yet ontologically "deanimated." Thus, the paradigm shift satisfies both those who insist on maintaining the DDR and those who claim that it has all along been receiving only lip service and should be explicitly loosened to include those who are "as good as dead." Even so, a number of practical caveats remain to be worked out for non-heart-beating protocols.



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\*  Article Document 48

Ittis, Ana Smith; Cherry, Mark J.

**Death revisited: rethinking death and the dead donor rule.**

Journal of Medicine and Philosophy 2010 June; 35(3): 223-241

**Abstract:** Traditionally, people were recognized as being dead using cardio-respiratory criteria: individuals who had permanently stopped breathing and whose heart had permanently stopped beating were dead. Technological developments in the middle of the twentieth century and the advent of the intensive care unit made it possible to sustain cardio-respiratory and other functions in patients with severe brain injury who previously would have lost such functions permanently shortly after sustaining a brain injury. What could and should physicians caring for such patients do? Significant advances in human organ transplantation also played direct and indirect roles in discussions regarding the care of such patients. Because successful transplantation requires that organs be removed from cadavers shortly after death to avoid organ damage due to loss of oxygen, there has been keen interest in knowing precisely when people are dead so that organs could be removed. Criteria for declaring death using neurological criteria developed, and today a whole brain definition of death is widely used and recognized by all 50 states in the United States as an acceptable way to determine death. We explore the ongoing debate over definitions of death, particularly over brain death or death determined using neurological criteria, and the relationship between definitions of death and organ transplantation.



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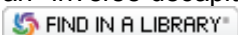
\*  Article Document 49

Khushf, George

**A matter of respect: a defense of the dead donor rule and of a "whole-brain" criterion for determination of death.**

Journal of Medicine and Philosophy 2010 June; 35(3): 330-364

**Abstract:** Many accounts of the historical development of neurological criteria for determination of death insufficiently distinguish between two strands of interpretation advanced by advocates of a "whole-brain" criterion. One strand focuses on the brain as the organ of integration. Another provides a far more complex and nuanced account, both of death and of a policy on the determination of death. Current criticisms of the whole-brain criterion are effective in refuting the first interpretation, but not the second, which is advanced in the 2008 President's Council report on the determination of death. In this essay, I seek to further develop this second strand of interpretation. I argue that policy on determination of death aligns moral, biological, and ontological death concepts. Morally, death marks the stage when respect is no longer owed. Biologically, death concerns integrated functioning of an organism as a whole. But the biological concepts are underdetermined. The moral concerns lead to selection of strong individuality concepts rather than weak ones. They also push criteria to the "far side" of the dying process. There is a countervailing consideration associated with optimizing the number of available organs, and this pushes to the "near side" of death. Policy is governed by a conviction that it is possible to align these moral and biological death concepts, but this conviction simply lays out an agenda. There is also a prescription-integral to the dead donor rule—that lexically prioritizes the deontic concerns and that seeks to balance the countervailing tendencies by using science-based refinements to make the line between life and death more precise. After showing how these concerns have been effectively aligned in the current policy, I present a modified variant of a "division" scenario and show how an "inverse decapitation problem" leads to a conclusive refutation of the nonbrain account of death.



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Article Document 50

Bernat, James L

**The debate over death determination in DCD.**

The Hastings Center report 2010 May-Jun; 40(3): 3



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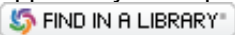
Article Document 51

Marquis, Don

**Are DCD donors dead?**

The Hastings Center report 2010 May-Jun; 40(3): 24-31

**Abstract:** Donation after cardiac death protocols are subject to two constraints. The first is that organ removal must occur as soon as possible after cardiac arrest. The second is that it must not occur so soon that the donor is not yet dead. Can both constraints be satisfied at once? DCD protocols are widely accepted, so arguments for them have apparently been persuasive. But this does not mean they are sound.



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\*  Article Document 52

Bernat, James L.

**The debate over death determination in DCD**

Hastings Center Report 2010 May-June; 40(3): 3



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<http://www.thehastingscenter.org/Publications/HCR/Archive.aspx> (link may be outdated)

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Article Document 53

Antonelli, Massimo; Azoulay, Elie; Bonten, Marc; Chastre, Jean; Citerio, Giuseppe; Conti, Giorgio; De Backer, Daniel; Lemaire, François; Gerlach, Herwig; Hedenstierna, Goran; Joannidis, Michael; Macrae, Duncan; Mancebo, Jordi; Maggiore, Salvatore M; Mebazaa, Alexandre; Preiser, Jean-Charles; Pugin, Jérôme; Wernerman, Jan; Zhang, Haibo

**Year in review in Intensive Care Medicine 2009. Part III: mechanical ventilation, acute lung injury and respiratory distress syndrome, pediatrics, ethics, and miscellanea.**

Intensive care medicine 2010 Apr ; 36(4): 567-84



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Article Document 54

Saudi Center for Organ Transplantation [SCOT]

**Deceased heart beating donor and organ transplantation in Saudi Arabia**

Saudi Journal of Kidney Diseases and Transplantation 2010 March; 21(2): 379-383



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Article Document 55

Bresnahan, Mary Jiang; Mahler, Kevin

**Ethical debate over organ donation in the context of brain death.**

Bioethics 2010 February; 24(2): 54-60

**Abstract:** This study investigated what information about brain death was available from Google searches for five major religions. A substantial body of supporting research examining online behaviors shows that information seekers use Google as their preferred search engine and usually limit their search to entries on the first page. For each of the five religions in this study, Google listings reveal ethical controversy about organ donation in the context of brain death. These results suggest that family members who go online to find information about organ donation in the context of brain death would find information about ethical controversy in the first page of Google listings. Organ procurement agencies claim that all major world religions approve of organ donation and do not address the ethical controversy about organ donation in the context of brain death that is readily available online.



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<http://www3.interscience.wiley.com/journal/123226235/issue> (link may be outdated)

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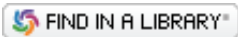
\*  Article Document 56

Joffe, Ari

**Are recent defences of the brain death concept adequate?**

Bioethics 2010 February; 24(2): 47-53

**Abstract:** Brain death is accepted in most countries as death. The rationales to explain why brain death is death are surprisingly problematic. The standard rationale that in brain death there has been loss of integrative unity of the organism has been shown to be false, and a better rationale has not been clearly articulated. Recent expert defences of the brain death concept are examined in this paper, and are suggested to be inadequate. I argue that, ironically, these defences demonstrate the lack of a defensible rationale for why brain death should be accepted as death itself. If brain death is death, a conceptual rationale for brain death being equivalent to death should be clarified, and this should be done urgently.



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<http://www3.interscience.wiley.com/journal/123226235/issue> (link may be outdated)

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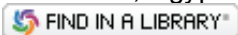


Book Document 57

Suwaylam, Muhammad MuhammadAhmad

**Mawt al-dimagh, dirasah tibbiyah qanúniyah fiqhiyah mu'asirah [Brain death, a medical, legal, and jurisprudential study]**

Alexandria, Egypt: Munsha'at al-Ma'arif, 2010. 277 p.

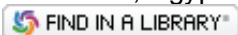


Book Document 58

Nadi, Muhammad Ibrahim Sa'd

**Mawt al-dimagh wa mawqif al-fiqh al-Islami minhu, dirasah muqaranah = Brain death and the attitude of Islamic jurisprudence towards it, a comparative study**

Alexandria, Egypt: Dar al-Fikr al-Jami'i, 2010. 139 p.



\*  Book Document 59

Prokovyev, Luka, ed.



**Article** Document 60

Chapman, Blake A

**Limiting donation after cardiac death: questions on consent.**

Health law journal 2010; 18: 159-86



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**Article** Document 61

Shah, Seema K; Miller, Franklin G

**Can we handle the truth? Legal fictions in the determination of death.**

American journal of law & medicine 2010; 36(4): 540-85

**Abstract:** Advances in life-saving technologies in the past few decades have challenged our traditional understandings of death. People can be maintained on life-support even after permanently losing the ability to breathe spontaneously and remaining unconscious and unable to interact meaningfully with others. In part because this group of people could help fulfill the growing need for organ donation, there has been a great deal of pressure on the way we determine death. The determination of death has been modified from the old way of understanding death as occurring when a person stops breathing, her heart stops beating, and she is cold to the touch. Today, physicians determine death by relying on a diagnosis of total brain failure or by waiting a short while after circulation stops. Evidence has emerged that the conceptual bases for these approaches to determining death are fundamentally flawed and depart substantially from our biological and common-sense understandings of death. We argue that the current approach to determining death consists of two different types of unacknowledged legal fictions. These legal fictions were developed for practices that are largely ethically legitimate but need to be reconciled with the law. However, the considerable debate over the determination of death in the medical and scientific literature has not informed the public of the fact that our current determinations of death do not adequately establish that a person has died. It seems unlikely that this information can remain hidden for long. Given the instability of the status quo and the difficulty of making the substantial legal changes required by complete transparency, we argue for a second-best policy solution of acknowledging the legal fictions involved in determining death. This move in the direction of greater transparency may someday result in allowing us to face squarely these issues and effect the legal changes necessary to permit ethically appropriate vital organ transplantation. Finally, this paper also provides the beginnings of a taxonomy of legal fictions, concluding that a more systematic theoretical treatment of legal fictions is warranted to understand their advantages and disadvantages across a variety of legal domains.



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\*  **News** Document 62

Sanghavi, Darshak

**The last decision**

New York Times Magazine 2009 December; p. 38-43



<http://www.nytimes.com/magazine/> (link may be outdated)

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\*  **Article** Document 63

Miller, Franklin G.; Truog, Robert D.

**The incoherence of determining death by neurological criteria: reply to John Lizza**

Kennedy Institute of Ethics Journal 2009 December; 19(4): 397-399



**Abstract:** Human life and death should be defined biologically. It is important not to conflate the definition of death with the criteria for when it has occurred. What is distinctively "human" from a scientific or normative perspective has nothing to do with what makes humans alive or dead. We are biological organisms, despite the fact that what is meaningful about human life is not defined in biological terms. Consequently, as in the rest of the realm of living beings, human beings die when they no longer function biologically as organisms. In contrast, a determination of exactly when death has occurred, required to serve various social purposes, combines social and normative considerations with biological facts.



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\*  Article Document 64

Lizza, John P.

**Commentary on "The incoherence of determining death by neurological criteria".**

Kennedy Institute of Ethics Journal 2009 December; 19(4): 393-395

**Abstract:** This commentary challenges the conclusions reached by Franklin Miller and Robert Truog in their criticism of the President's Council's White Paper, "Controversies in the Determination of Death." I agree with much of Miller and Truog's criticism of the rationale offered by the President's Council for accepting neurological criteria for determining death but argue that they too quickly dismiss the alternative rationale of determining death by neurological criteria-i.e., the destruction of the psychophysical integrity of the human being that occurs when the potential for consciousness and every other mental function is lost due to catastrophic injury to the brain. By focusing on the death of bodies instead of human beings, their view absurdly implies that decapitation would not necessarily result in one's death. Since total brain failure is a form of physiological decapitation, the neurological criterion coheres perfectly well with the ordinary understanding of decapitation as death.



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Article Document 65

Verheijde, Joseph L; Rady, Mohamed Y; McGregor, Joan L

**Brain death, states of impaired consciousness, and physician-assisted death for end-of-life organ donation and transplantation.**

Medicine, health care, and philosophy 2009 Nov ; 12(4): 409-21

**Abstract:** In 1968, the Harvard criteria equated irreversible coma and apnea (i.e., brain death) with human death and later, the Uniform Determination of Death Act was enacted permitting organ procurement from heart-beating donors. Since then, clinical studies have defined a spectrum of states of impaired consciousness in human beings: coma, akinetic mutism (locked-in syndrome), minimally conscious state, vegetative state and brain death. In this article, we argue against the validity of the Harvard criteria for equating brain death with human death. (1) Brain death does not disrupt somatic integrative unity and coordinated biological functioning of a living organism. (2) Neurological criteria of human death fail to determine the precise moment of an organism's death when death is established by circulatory criterion in other states of impaired consciousness for organ procurement with non-heart-beating donation protocols. The criterion of circulatory arrest 75 s to 5 min is too short for irreversible cessation of whole brain functions and respiration controlled by the brain stem. (3) Brain-based criteria for determining death with a beating heart exclude relevant anthropologic, psychosocial, cultural, and religious aspects of death and dying in society. (4) Clinical guidelines for determining brain death are not consistently validated by the presence of irreversible brain stem ischemic injury or necrosis on autopsy; therefore, they do not completely exclude reversible loss of integrated neurological functions in donors. The questionable reliability and varying compliance with these guidelines among institutions amplify the risk of determining reversible states of impaired consciousness as irreversible brain death. (5) The scientific uncertainty of defining and determining states of impaired consciousness including brain death have been neither disclosed to the general public nor broadly debated by the medical community or by legal and religious scholars. Heart-beating or non-heart-beating organ procurement from patients with impaired consciousness is de facto a concealed practice of physician-assisted death, and therefore, violates both criminal law and the central tenet of medicine not to do harm to patients. Society must decide if physician-assisted death is permissible and desirable to resolve the conflict about procuring organs from patients with impaired consciousness within the context of the

perceived need to enhance the supply of transplantable organs.



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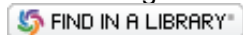


Article Document 66

Andrusko, Dave

**Misdiagnosed for 23 years, Rom Houben is a moral lesson for our time**

National Right to Life News 2009 November/December; 36(11-12): 15, 17



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<http://www.nrclc.org/news> (link may be outdated)

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\*  Article Document 67

Verheijde, Joseph L.; Rady, Mohamed Y.; McGregor, Joan L.

**Brain death, states of impaired consciousness, and physician-assisted death for end-of-life organ donation and transplantation.**

Medicine, Health Care, and Philosophy 2009 November; 12(4): 409-421

**Abstract:** In 1968, the Harvard criteria equated irreversible coma and apnea (i.e., brain death) with human death and later, the Uniform Determination of Death Act was enacted permitting organ procurement from heart-beating donors. Since then, clinical studies have defined a spectrum of states of impaired consciousness in human beings: coma, akinetic mutism (locked-in syndrome), minimally conscious state, vegetative state and brain death. In this article, we argue against the validity of the Harvard criteria for equating brain death with human death. (1) Brain death does not disrupt somatic integrative unity and coordinated biological functioning of a living organism. (2) Neurological criteria of human death fail to determine the precise moment of an organism's death when death is established by circulatory criterion in other states of impaired consciousness for organ procurement with non-heart-beating donation protocols. The criterion of circulatory arrest 75 s to 5 min is too short for irreversible cessation of whole brain functions and respiration controlled by the brain stem. (3) Brain-based criteria for determining death with a beating heart exclude relevant anthropologic, psychosocial, cultural, and religious aspects of death and dying in society. (4) Clinical guidelines for determining brain death are not consistently validated by the presence of irreversible brain stem ischemic injury or necrosis on autopsy; therefore, they do not completely exclude reversible loss of integrated neurological functions in donors. The questionable reliability and varying compliance with these guidelines among institutions amplify the risk of determining reversible states of impaired consciousness as irreversible brain death. (5) The scientific uncertainty of defining and determining states of impaired consciousness including brain death have been neither disclosed to the general public nor broadly debated by the medical community or by legal and religious scholars. Heart-beating or non-heart-beating organ procurement from patients with impaired consciousness is de facto a concealed practice of physician-assisted death, and therefore, violates both criminal law and the central tenet of medicine not to do harm to patients. Society must decide if physician-assisted death is permissible and desirable to resolve the conflict about procuring organs from patients with impaired consciousness within the context of the perceived need to enhance the supply of transplantable organs.



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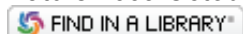


Article Document 68

Evans, David W.

**Brainstem tests not adequate to diagnose death in organ donors. [letter]**

Nature 2009 October 29; 461(7268): 1198



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<http://www.nature.com/nature/journal/v461/n7268/> (link may be outdated)



\*  Article Document 69

Zeiler, Kristin

**Deadly pluralism? Why death-concept, death-definition, death-criterion and death-test pluralism should be allowed, even though it creates some problems.**

Bioethics 2009 October; 23(8): 450-459

**Abstract:** Death concept, death definition, death criterion and death test pluralism has been described by some as a problematic approach. Others have claimed it to be a promising way forward within modern pluralistic societies. This article describes the New Jersey Death Definition Law and the Japanese Transplantation Law. Both of these laws allow for more than one death concept within a single legal system. The article discusses a philosophical basis for these laws starting from John Rawls' understanding of comprehensive doctrines, reasonable pluralism and overlapping consensus. It argues for the view that a certain legal pluralism in areas of disputed metaphysical, philosophical and/or religious questions should be allowed, as long as the disputed questions concern the individual and the resulting policy, law or acts based on the policy/law, do not harm the lives of other individuals to an intolerable extent. However, while this death concept, death definition, death criterion and death test pluralism solves some problems, it creates others.



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<http://www3.interscience.wiley.com/journal/122577114/issue> (link may be outdated)

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\*  Article Document 70

Rubenstein, Alan; Lizza, John P.; Menzel, Paul T.; Shewmon, Alan; Lee, Daniel E.; Arbisser, Lisa Brothers

**And She's Not Only Merely Dead, She's Really Mostly Sincerely Dead [letters and reply]**

Hastings Center Report 2009 September-October 39(5): 4-7



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\*  Article Document 71

Finucane, Thomas E.; Howsepian, Avak Albert; Rosenberg, Robert N.

**Controversies about brain death [letters and reply]**

JAMA: The Journal of the American Medical Association 2009 July 22; 302(4): 381-382



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<http://jama.ama-assn.org/> (link may be outdated)

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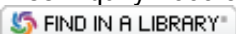


\*  Article Document 72

Cohen, Elliot D.

**Redefining death**

Free Inquiry 2009 June-July; 29(4): 50-51



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\*  Article Document 73

Miller, Franklin G.; Truog, Robert D.

**The incoherence of determining death by neurological criteria: a commentary on "Controversies in the determination of death", a white paper by the President's Council on Bioethics.**

Kennedy Institute of Ethics Journal 2009 June; 19(2): 185-193

**Abstract:** Traditionally the cessation of breathing and heart beat has marked the passage from life to death. Shortly after death was determined, the body became a cold corpse, suitable for burial or cremation. Two technological changes in the second half of the twentieth century prompted calls for a new, or at least expanded, definition of death: the development of intensive care medicine, especially the use of mechanical ventilators, and the advent of successful transplantation of vital organs. Patients with profound neurological damage, leaving them incapable of breathing on their own and in an irreversible coma, could be maintained for some period of time with the aid of mechanical ventilation. The situation of these patients posed two ethical questions. Is it appropriate to stop life-sustaining treatment? If so, is it acceptable to retrieve vital organs for transplantation to save the lives of others before stopping treatment? In 1968, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death proposed that death could be determined on the basis of neurological criteria, thus providing a positive answer to these two questions (Ad Hoc Committee 1968). According to the position of this committee, patients diagnosed with the cessation of brain function are dead, despite the fact that they breathe and circulate blood with the aid of mechanical ventilation.



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\*  Article Document 74

Olick, Robert S.; Braun, Eli A.; Potash, Joel

**Accommodating religious and moral objections to neurological death.**

Journal of Clinical Ethics 2009 Summer; 20(2): 183-191



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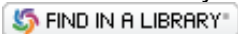


\*  Article Document 75

Powner, David J.

**Certification of brain death: take care.**

Lancet 2009 May 9; 373(9675): 1587-1589



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<http://www.thelancet.com/journals/lancet/issue/current> (link may be outdated)

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Article Document 76

Murphy, J F A

**Brain death in 1968 and forty years on.**

Irish medical journal 2009 May; 102(5): 136



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\*  Article Document 77

Zeiler, Kristin

**Self and other in global bioethics: critical hermeneutics and the example of different death concepts**

Medicine, Health Care, and Philosophy 2009 May; 12(2): 137-145

**Abstract:** Our approach to global bioethics will depend, among other things, on how we answer the questions whether global bioethics is possible and whether it, if it is possible, is desirable. Our approach to global bioethics will also vary depending on whether we believe that the required bioethical deliberation should take as its principal point of departure that which we have in common or that which we have in common and that on which we differ. The aim of this article is to elaborate a theoretical underpinning for a bioethics that acknowledges the diversity of traditions and experiences without leading to relativism. The theoretical underpinning will be elaborated through an exploration of the concepts of sameness, otherness, self and other, and through a discussion of the conditions for understanding and critical reflection. Furthermore, the article discusses whether the principle of respect for the other

as both the same and different can function as the normative core of this global bioethics. The article also discusses the New Jersey Death Definition Law and the Japanese Transplantation Law. These laws are helpful in order to highlight possible implications of the principle of respect for the other as both the same and different. Both of these laws open the door to more than one concept of death within one and the same legal system. Both of them relate preference for a particular concept of death to religious and/or cultural beliefs.



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\*  Article Document 78

Rosenberg, Roger N.

**Consciousness, coma, and brain death -- 2009.**

JAMA: The Journal of the American Medical Association 2009 March 18; 301(11): 1172-1174



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<http://jama.ama-assn.org/content/vol301/issue11/> (link may be outdated)

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\*  Article Document 79

Torpy, Janet M.; Kincaid, Jennifer L.; Glass, Richard M.

**Brain death -- JAMA patient page.**

JAMA: The Journal of the American Medical Association 2009 March 18; 301(11): 1192



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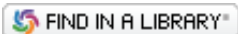


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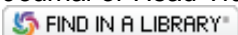


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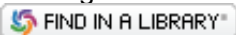


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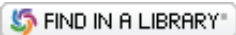


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**Brain death and organ donation: some pro-life groups are questioning the criteria for organ transplants. Pope John Paul II would have disagreed.**

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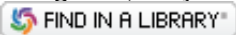


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**Abstract:** We discuss the meaning of "being alive" and "being dead." Our primary aim is to pave the way for a sound and accurate ethical debate concerning these two concepts. In particular, we analyze a metabolic approach and a genetic one and discuss the reasons for their failure to constitute a good starting point for successive debates. We argue that any ethical or social discussion of topics involving life and death must introduce cultural constructs such as, on the one hand, the concept of clinical death and, on the other hand, the concept of existence. We argue that these two cultural constructs, although consistent with biomedical knowledge, cannot be ontologically grounded in it. To conclude, we apply our findings to the case of human embryos.

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### N.Y. boy on life support in D.C. dies; parents pressed court not to declare son dead

Washington Post 2008 November 17; p. B1, B4

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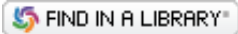
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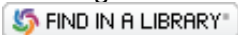
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Bosek, Maria Sue Dewolf  
**Respecting a patient's religious values: what does this require?**  
JONA'S Healthcare Law, Ethics and Regulation 2008 October-December; 10(4): 100-105  
**Abstract:** An Orthodox Jewish father is approached by a physician to discuss potential treatment options for his critically injured infant son. The possibility that he might progress to a determination of brain death was raised. The father stated and a rabbi concurred that his religion only acknowledges cardiopulmonary death. This article will address the following ethical question: "what does it mean to respect another person's values?" An overview of brain death and culture will be presented. A concept analysis for respect will be presented and used to analyze the case. Recommendations for actions that nurse managers, nurses, and other healthcare professionals could take to promote their ability to respect a patient's values and beliefs will be made.



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Jotkowitz, A.

**Theological reflections on donation after circulatory death: the wisdom of Paul Ramsey and Moshe Feinstein**

Journal of Medical Ethics 2008 October; 34(10): 706-709

**Abstract:** Due to the worldwide shortage of organs for transplantation, there has been an increased use of organs obtained after circulatory death alone. A protocol for this procedure has recently been approved by a major transplant consortium. This development raises serious moral and ethical concerns. Two renowned theologians of the previous generation, Paul Ramsey and Moshe Feinstein, wrote extensively on the ethical issues relating to transplantation, and their work has much relevance to current moral dilemmas. Their writings relating to definition of death, organ transplantation and the care of the terminally ill are briefly presented, and their potential application to the moral problem of organ donation after circulatory death is discussed.



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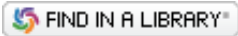


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**Should individuals choose their definition of death?**

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**Abstract:** Alireza Bagheri supports a policy on organ procurement where individuals could choose their own definition of death between two or more socially accepted alternatives. First, we claim that such a policy, without any criterion to distinguish accepted from acceptable definitions, easily leads to the slippery slope that Bagheri tries to avoid. Second, we suggest that a public discussion about the circumstances under which the dead donor rule could be violated is more productive of social trust than constantly moving the line between life and death.



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Haas, John M.

**Absolute versus prudential certitude in criteria for determining death**

Ethics and Medics 2008 July; 33(7): 2 p.



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Sethi, N.K.; Sethi, P.K.; Torgovnick, J.; Arsura, E.; Schaul, N.; Labar, D.

**EMG artifact in brain death electroencephalogram, is it a cry of "medullary death"?**

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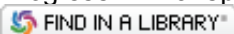


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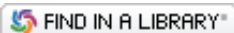


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Macdonald, Mary Ellen; Liben, Stephen; Carnevale, Franco A.; Cohen, S. Robin

**Signs of life and signs of death: brain death and other mixed messages at the end of life.**

Journal of Child Health Care 2008 June; 12(2): 92-105



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JAMA: The Journal of the American Medical Association 2008 May 14; 299(18): 2232



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Applbaum, Arthur Isak; Tilburt, Jon C.; Collins, Michael T.; Wendler, David

**A family's request for complementary medicine after patient brain death**

JAMA: The Journal of the American Medical Association 2008 May 14; 299(18): 2188-2193

**Abstract:** A 19-year-old woman living with relatives in the United States who was admitted for elective cranial

surgery for complications related to a congenital disorder developed an acute intracranial hemorrhage 10 days after surgery. The patient was declared dead following repeat negative apnea tests. The patient's father requested that the treating team administer an unverified traditional medicinal substance to the patient. Because of the unusual nature of this request, the treating team called an ethics consultation. The present article reviews this case and discusses other cases that share key features to determine whether and when it is appropriate to accommodate requests for interventions on patients who have been declared dead.



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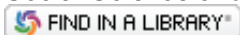


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Moalimishak, Mohamed Rashad

**THE ETHICAL EVALUATION OF BRAIN DEAD PERSONS AND ORGAN TRANSPLANTATION IN CONTEMPORARY MUSLIM ETHICS**

Ann Arbor, MI: ProQuest Information and Learning/UMI, 2008. 203 p.

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**CONTROVERSIES IN THE DETERMINATION OF DEATH: A WHITE PAPER BY THE PRESIDENT'S COUNCIL ON BIOETHICS**

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Ahmad, 'Alí Muhammad 'Alí

**Mi'yar tahaquq al-wafah wa ma yata'allaq biha min qadaya hadlthah fi al-fiqh al-Islamí (al-mawt al-rahím) = criterion for establishing the occurrence of death and other pertinent new issues in Islamic jurisprudence (euthanasia)**

Alexandria, Egypt: Dar al-Fikr al-Jami'í, 2008: 339 p.

**Abstract:** This book discusses the criteria for establishing death in Islamic jurisprudence. It consists of a general introduction and four main chapters. The introduction gives background information about the subject and points out indications of God's honoring of humans both during life and after death. It also discusses the juristic views on the rulings pertaining to the severed body parts, obtained either during life or after death. The first chapter focuses on physicians' criteria for establishing death. The second chapter deals with jurists' criteria for establishing death. The third chapter deals with the juristic discussions on different resuscitation systems. The fourth chapter discusses the juristic views pertaining to ways of dealing with cadavers.



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May, William E.

**Defining death and organ transplantation**

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In their: Case Studies in Pharmacy Ethics. 2nd ed. New York; Oxford: Oxford University Press, 2008: 274-291

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**A Code of practice for the diagnosis and confirmation of death**

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Shemie, Sam D.; Lazar, Neil; Dickens, Bernard M.

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**Establishing the moment of death in transplantation procedures**

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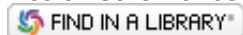
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Machado, Calixto; Korein, J.; Ferrer, Y.; Portela, L.; García, M. de la C.; Chinchilla, M.; Machado, Y.; Machado, Y.;

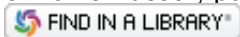


Manero, J.M.

**The Declaration of Sydney on human death**

Journal of Medical Ethics 2007 December; 33(12): 699-703

**Abstract:** On 5 August 1968, publication of the Harvard Committee's report on the subject of "irreversible coma" established a standard for diagnosing death on neurological grounds. On the same day, the 22nd World Medical Assembly met in Sydney, Australia, and announced the Declaration of Sydney, a pronouncement on death, which is less often quoted because it was overshadowed by the impact of the Harvard Report. To put those events into present-day perspective, the authors reviewed all papers published on this subject and the World Medical Association web page and documents, and corresponded with Dr A G Romualdez, the son of Dr A Z Romualdez. There was vast neurological expertise among some of the Harvard Committee members, leading to a comprehensible and practical clinical description of the brain death syndrome and the way to diagnose it. This landmark account had a global medical and social impact on the issue of human death, which simultaneously lessened reception of the Declaration of Sydney. Nonetheless, the Declaration of Sydney faced the main conceptual and philosophical issues on human death in a bold and forthright manner. This statement differentiated the meaning of death at the cellular and tissue levels from the death of the person. This was a pioneering view on the discussion of human death, published as early as in 1968, that should be recognised by current and future generations.



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Hughes, James

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Beecher, Henry K.

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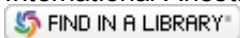


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Lowenstein, E.

**Defining brain death: motivations and future directions**

International Anesthesiology Clinics 2007 Fall; 45(4): 121-133



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**Draft principles and guidelines for non-heart-beating organ donation**

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DuBois, James

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Hostetter, Larry

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National Catholic Bioethics Quarterly 2007 Autumn; 7(3): 499-504



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Diamond, Eugene F.

**John Paul II and brain death**

National Catholic Bioethics Quarterly 2007 Autumn; 7(3): 491-497



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Eberl, Jason T.

**Dualist and animalist perspectives on death: a comparison with Aquinas**

National Catholic Bioethics Quarterly 2007 Autumn; 7(3): 477-489



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Brown, Grattan T.

**Reading the signs of death: a theological analysis**

National Catholic Bioethics Quarterly 2007 Autumn; 7(3): 467-476



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Baumrucker, Steven J.; Stolick, Matt; Morris, Gerald M.; Carter, Gregory T.; Sheldon, Joanne E.

**Brain death and organ transplantation.**

American Journal of Hospice and Palliative Care 2007 August-September; 24(4): 325-330



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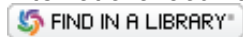


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Rasekh, Mohammad; Ayati, S.M.R.

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Beard, Edward L. Jr.; Johnson, Larry W.

**Conversations in ethics**

JONA's Healthcare Law, Ethics, and Regulation 2007 July-September; 9(3): 95-96



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Bard, Terry R.

**Refusal of brain death diagnosis: a rabbi's response**

JONA's Healthcare Law, Ethics, and Regulation 2007 July-September; 9(3): 92-94



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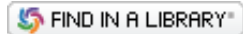


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Anderson, Janice A.; Vernaglia, Lawrence W.; Morigan, Shirley P.

**Refusal of brain death diagnosis: the health lawyers' perspective**

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Bosek, Marci Sue DeWolf

**Refusal of brain death diagnosis: the ethicist's response**

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McClusky, Joan

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Griniezakis, Archimandrite Makarios

**Legal and ethical issues associated with brain death**

Ethics and Medicine: An International Journal of Bioethics 2007 Summer; 23(2): 113-117



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Darmadipura, M. Sajid

**Brain stem death, persistent vegetative state and asking to die in the Indonesian Moslem society [abstract]**

Eubios Journal of Asian and International Bioethics 2007 May; 17(3): 80



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Frid, Ingvar; Haljamäe, Hengo; Öhlén, Joakim; Bergbom, Ingegerd

**Brain death: close relatives' use of imagery as a descriptor of experience**

Journal of Advanced Nursing 2007 April; 58(1): 63-71



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**Understanding brain death diagnosis -- II**

Ethics and Medics 2007 April; 32(4): 3-4



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**The concept of brain death did not evolve to benefit organ transplants**

Journal of Medical Ethics 2007 April; 33(4): 197-200

**Abstract:** Although it is commonly believed that the concept of brain death (BD) was developed to benefit organ

transplants, it evolved independently. Transplantation owed its development to advances in surgery and immunosuppressive treatment; BD owed its origin to the development of intensive care. The first autotransplant was achieved in the early 1900s, when studies of increased intracranial pressure causing respiratory arrest with preserved heartbeat were reported. Between 1902 and 1950, the BD concept was supported by the discovery of EEG, Crile's definition of death, the use of EEG to demonstrate abolition of brain potentials after ischaemia, and Crafoord's statement that death was due to cessation of blood flow. Transplantation saw the first xenotransplant in humans and the first unsuccessful kidney transplant from a cadaver. In the 1950s, circulatory arrest in coma was identified by angiography, and the death of the nervous system and coma dépassé were described. Murray performed the first successful kidney transplant. In the 1960s, the BD concept and organ transplants were instantly linked when the first kidney transplant using a brain-dead donor was performed; Schwab proposed to use EEG in BD; the Harvard Committee report and the Sydney Declaration appeared; the first successful kidney, lung and pancreas transplants using cadaveric (not brain-dead) donors were achieved; Barnard performed the first human heart transplant. This historical review demonstrates that the BD concept and organ transplantation arose separately and advanced in parallel, and only began to progress together in the late 1960s. Therefore, the BD concept did not evolve to benefit transplantation.



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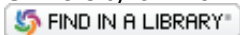


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Goldsmith, Jason L.

**Wanted! Dead and/or alive: choosing among the not-so-uniform statutory definitions of death**

University of Miami Law Review 2007 April; 61(3): 871-930



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Lago, Patrícia M.; Piva, Jefferson; Garcia, Pedro Celiny; Troster, Eduardo; Bousso, Albert; Sarno, Maria Olivia; Torreão, Lara; Sapolnik, Roberto

**Brain death: medical management in seven Brazilian pediatric intensive care units**

Jornal de Pediatria 2007 March-April; 83(2): 133-140



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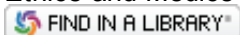


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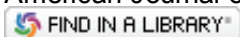


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Eberl, Jason T.

**John P. Lizza. Persons, Humanity, and the Definition of Death [book review]**

American Journal of Bioethics 2007 March; 7(3): 55-57



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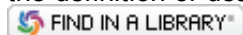
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Bagheri, A.

**Individual choice in the definition of death**

Journal of Medical Ethics 2007 March; 33(3): 146-149

**Abstract:** While there are numerous doubts, controversies and lack of consensus on alternative definitions of human death, it is argued that it is more ethical to allow people to choose either cessation of cardio-respiratory function or loss of entire brain function as the definition of death based on their own views. This paper presents the law of organ transplantation in Japan, which allows people to decide whether brain death can be used to determine their death in agreement with their family. Arguably, Japan could become a unique example of individual choice in the definition of death if the law is revised to allow individuals choose definition of death independently of their family. It suggests that such an approach is one of the reasonable policy options a country can adopt for legislation on issues related to the definition of death.



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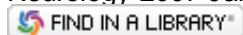


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**Late recovery from the minimally conscious state: ethical and policy implications**

Neurology 2007 January 23; 68(4): 304-307



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**Death and transplantation: let's try to get things methodologically straight**

Bioethics 2007 January; 21(1): 32-40

**Abstract:** The purpose of this paper is methodological. I begin by showing the methodological frailties of both the heart and brain approach to the criteria of death used in connection with organ transplantation. I then clarify what a definition is. Finally, I propose to abandon the definition of death, and suggest a pragmatic definition of 'explantability window'.



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Sánchez Sorondo, Marcelo, ed.

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Vatican City: Pontifical Academy of Sciences, 2007. 464 p.

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Bacigalupo, Félix; Huerta, Daniela; Montefusco-Siegmund, Rodrigo

**The debate about death: an imperishable discussion?**

Biological Research 2007; 40(4): 523-534



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Chau, P-L; Herring, Jonathan

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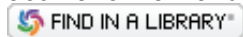


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Tavakkoli, Saeid Nazari

**A comparison between brain death and unstable life: Shi'ite perspective**

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Crippen, David W.; Whetstine, Leslie M.

**Ethics review: dark angels -- the problem of death in intensive care.**

Critical Care 2007; 11(1): 202



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**Diagnosis of brain death in children: technology and the inadequate lexicon of death**

Lancet Neurology 2007; 6: 87-88



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**Understanding and misunderstanding death**

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Glannon, Walter

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**Respecting rights ... to death [letter and reply]**

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**Research and patients in a permanent vegetative state [letter and reply]**

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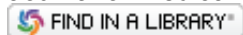


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Journal of Medical Ethics 2006 October; 32(10): 606-607, 609-611



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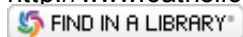
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Glatz, Carol

**[Vatican resuscitates issue of whether brain death means total death](#)**

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**End-of-life decision-making and the politics of the fetus**

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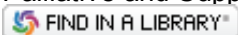


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Fins, Joseph J.

**Affirming the right to care, preserving the right to die: disorders of consciousness and neuroethics after Schiavo**

Palliative and Supportive Care 2006 June; 4(2): 169-178



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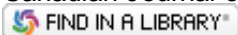


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Wijdicks, Eelco F.M.

**The clinical criteria of brain death throughout the world: why has it come to this? = Les critères cliniques de mort encéphalique à travers le monde: pour quoi en arriver là [editorial]**

Canadian Journal of Anaesthesia 2006 June; 53(6): 540-543



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Baron, Leonard; Shemie, Sam D.; Teitelbaum, Jeannie; Doig, Christopher James

**Brief review: history, concept and controversies in the neurological determination of death**

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Hornby, Karen; Shemie, Sam D.; Teitelbaum, Jeanni; Doig, Christopher

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Shepherd, Lois

**In respect of people living in a permanent vegetative state -- and allowing them to die**

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Mistry, Parul R.

**Donation after cardiac death: an overview**

Mortality 2006 May; 11(2): 182-195



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Kim, Jung Ran; Fisher, Murray; Elliott, Doug

**Knowledge levels of Korean intensive care nurses towards brain death and organ transplantation**

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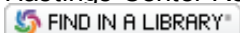


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Youngner, Stuart; Chiong, Winston

**Matters of "life" and "death" [letter and reply]**

Hastings Center Report 2006 May-June; 36(3): 5, 5-6



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Burck, Russell; Anderson-Shaw, Lisa; Sheldon, Mark; Egan, Erin A.

**The clinical response to brain death: a policy proposal**

JONA's Healthcare Law, Ethics, and Regulation 2006 April-June; 8(2): 53-59

**Abstract:** The ethical and scientific literature reflects a certain amount of controversy and confusion surrounding the concept of death by neurological criteria, or brain death. The issues surrounding brain death occur with limited frequency for those working in acute critical care settings. Even so, the literature and our own experiences evidence the discomfort of caregivers and policymakers when dealing with brain-dead patients and their family and loved ones. One particular area in which there seems to be significant diversity of opinion is what should occur when death by neurological criteria is pronounced. At some hospitals, when the patient is pronounced dead by neurological criteria, the support equipment is removed from the body immediately and the body is prepared for visitation by family or is transported to the morgue. In other hospitals, support equipment is maintained for a certain limited period to allow the family to be present when the equipment is ultimately removed. In general, however, it appears that institutional guidelines and policy are vague, at best, or often silent about the issue of when, how, and, to some extent, who decides what is done with the body. This policy paper discusses the confusion of care providers as well as lay persons related to the general concepts of death by neurological criteria. In addition, alternative approaches to the withdrawal of support equipment are examined. This article may also allow nursing administrators to better understand the importance of establishing specific clinical guidelines for their staff related to patients declared dead by neurological criteria. Our conclusion is that a universal policy should be adopted whereby all institutions develop the same guidelines concerning when and how treatment modalities should be withdrawn on their brain-dead patients. Such policy guidelines may not extinguish the misconceptions, misunderstandings, and discomforts that are present with a diagnosis of brain death, but it would certainly allow for more consistent actions on the part of the caregivers. Consistency would substantially benefit caregivers, families, and society alike.



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Hershenov, David B.

**The death of a person**

Journal of Medicine and Philosophy 2006 April; 31(2): 107-120

**Abstract:** Drawing upon Lynne Baker's idea of the person derivatively possessing the properties of a constituting organism, I argue that even if persons aren't identical to living organisms, they can each literally die a biological death. Thus we can accept that we're not essentially organisms and can still die without having to admit that there are two concepts and criteria of death as Jeff McMahan and Robert Veatch do. Furthermore, we can accept James Bernat's definition of "death" without having to insist, as he does, that persons are identical to organisms or that persons can only die metaphorical deaths.



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Shemie, Sam D.; Doig, Christopher; Dickens, Bernard; Byrne, Paul; Wheelock, Brian; Rocker, Graeme; Baker, Andrew; Seland, T. Peter; Guest, Cameron; Cass, Dan; Jefferson, Rosella; Young, Kimberlu; Teitelbaum, Jeanne  
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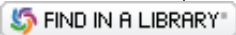


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McMahan, Jeff

**An alternative to brain death**

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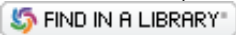


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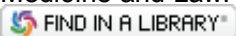


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Baltimore, MD: Johns Hopkins University Press, 2006. 212 p.

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Georges Cardinal Cottier; Alfonso Cardinal Lopez Trujillo; Carlo Cardinal Maria Martini; Elio Bishop Sgreccia

[Why the Concept of Brain Death is Valid as a Definition of Death](#)

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Bellanger, Silke; Steinbrecher, Aline

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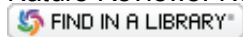


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**Science and society: death, unconsciousness and the brain**

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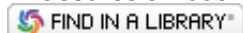


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**The death of whole-brain death: the plague of the disaggregators, somaticists, and mentalists**

Journal of Medicine and Philosophy 2005 August; 30(4): 353-378

**Abstract:** In its October 2001 issue, this journal published a series of articles questioning the Whole-Brain-based definition of death. Much of the concern focused on whether somatic integration—a commonly understood basis for the whole-brain death view—can survive the brain's death. The present article accepts that there are insurmountable problems with whole-brain death views, but challenges the assumption that loss of somatic integration is the proper basis for pronouncing death. It examines three major themes. First, it accepts the claim of the "disaggregators" that some behaviors traditionally associated with death can be unbundled, but argues that other behaviors (including organ procurement) must continue to be associated. Second, it rejects the claims of the "somaticists," that the integration of the body is critical, arguing instead for equating death with the irreversible loss of "embodied consciousness," that is, the loss of integration of bodily and mental function. Third, it defends higher-brain views against the charge that they are necessarily "mentalist," that is, that they equate death with losing some mental function such as consciousness or personhood. It argues, instead, for the integration of bodily and mental function as the critical feature of human life and that its irreversible loss constitutes death.



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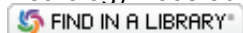


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**Imperative of "signs of clinical death" for organ transplants: message to the Pontifical Academy of Sciences**

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**Potentiality, irreversibility, and death**

Journal of Medicine and Philosophy 2005 February; 30(1): 45-64

**Abstract:** There has been growing concern about whether individuals who satisfy neurological criteria for death or who become non-heart-beating organ donors are really dead. This concern has focused on the issue of the potential for recovery that these individuals may still have and whether their conditions are irreversible. In this article I examine the concepts of potentiality and irreversibility that have been invoked in the discussions of the definition of death and non-heart-beating organ donation. I initially focus on the recent challenge by D. Alan Shewmon to accepting any neurological criterion of death. I argue that Shewmon relies on a problematic and unrealistic concept of potentiality, and that a better, more realistic concept of potentiality is consistent with accepting a neurological criterion for death. I then turn to an analysis of how the concept of irreversibility has been used in discussion of non-heart-beating organ donation. Similarly, I argue that some participants in this discussion have invoked a problematic and unrealistic concept of irreversibility. I then propose an alternative, more realistic account of irreversibility that explains how "irreversibility" should be understood in the definition and criteria of death.



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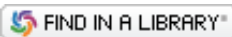


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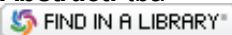
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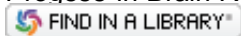


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Progress in Brain Research 2005; 150: 369-379



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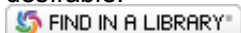
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Sato, Hajime; Akabayashi, Akira; Kai, Ichiro

**Public appraisal of government efforts and participation intent in medico-ethical policymaking in Japan: a large scale national survey concerning brain death and organ transplant**

BMC Medical Ethics [Online] 2005; 6(1): 12 p. Accessed: <http://www.biomedcentral.com/1472-6939/6/1> [18 February 2005]

**Abstract:** BACKGROUND: Public satisfaction with policy process influences the legitimacy and acceptance of policies, and conditions the future political process, especially when contending ethical value judgments are involved. On the other hand, public involvement is required if effective policy is to be developed and accepted. METHODS: Using the data from a large-scale national opinion survey, this study evaluates public appraisal of past government efforts to legalize organ transplant from brain-dead bodies in Japan, and examines the public's intent to participate in future policy. RESULTS: A relatively large percentage of people became aware of the issue when government actions were initiated, and many increasingly formed their own opinions on the policy in question. However, a significant number (43.3%) remained unaware of any legislative efforts, and only 26.3% of those who were aware provided positive appraisals of the policymaking process. Furthermore, a majority of respondents (61.8%) indicated unwillingness to participate in future policy discussions of bioethical issues. Multivariate analysis revealed the following factors are associated with positive appraisals of policy development: greater age; earlier opinion formation; and familiarity with donor cards. Factors associated with likelihood of future participation in policy discussion include younger age, earlier attention to the issue, and knowledge of past government efforts. Those unwilling to participate cited as their reasons that experts are more knowledgeable and that the issues are too complex. CONCLUSIONS: Results of an opinion survey in Japan were presented, and a set of factors statistically associated with them were discussed. Further efforts to improve policy making process on bioethical issues are desirable.



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