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An Application of Hierarchicalism to Anencephalic Newborns

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A survey of modern medical practice reveals no shortage of ethical controversies. The root of these controversies is often a conflict between two or more ethical norms. According to the idea of hierarchicalism, such conflicts are resolved by devising a hierarchy of norms, giving priority of compliance to the “higher” norm and negating moral accountability for failing to comply with the “lower” norm. Intuitively, such an approach seems valid, as we have all witnessed situations in which absolute norms conflict and an agent must make a decision to follow the one and reject the other. The difficulty, however, comes in assessing which norm has priority. Therefore, a hierarchical approach to any moral question requires careful consideration of the relevant factors of each case and an assessment of whether “the duty chosen either counterbalances or overbalances the duty not chosen” (Feinberg and Feinberg, 1993, p. 32). Based on this counterbalancing-overbalancing criterion, I will apply a hierarchical framework to the question of using anencephalic newborns as organ donors, and will show that the morally correct response is an emphatic “no.”

Occurring in about one in 1000 births, anencephaly is a congenital defect characterized by the absence of the cerebral cortex and the presence of a rudimentary brainstem (Sullivan, 2003). The condition is terminal, with death usually occurring within three days of birth (Lagay, 2004). Given their lack of actual or even potential sentience, some have argued that anencephalic newborns are non-persons and that they should be treated as brain dead. Singer and Kuhse, for example, assert that anencephalics are among those “who are humans in the sense of being members of the species *Homo sapiens* but not in the morally significant sense of having the distinctively human characteristics...” (1985, p. 123). Because they lack the requisite “indicators of humanhood,” empirical functionalists would contend that anencephalics should be used as organ donors before clinical death to ensure that “their short and tragic lives have some redeeming value” (Rae, 1993, p. 239).

Indeed, in 1994, the American Medical Association’s (AMA) Council on Ethical and Judicial Affairs deemed it ethically acceptable to transplant a living anencephalic’s organs provided there was parental consent. The Council’s reasoning virtually paralleled that of the empirical functionalists. The decision was based on the assumptions of the newborns’ immanent death and complete lack of consciousness, as well as the high frequency of parental requests that their child’s organs be donated (Lagay, 2004).

By contrast others would contend that, despite a lack of higher brain function and with the prospect of certain death, anencephalic newborns are nonetheless persons who should be treated with appropriate dignity. As Condic (2003) argues, brain death is not equivalent to the loss of higher brain function; rather, it is the loss of coordinated integrated function of the body as a whole. To be sure, anencephalic newborns possess coordinated integrated function. Although their brain-wave activity is abnormal, anencephalics still possess brain-wave activity

and are therefore still alive. According to ontological personalism, personhood is inherent in the human organism and is not measured by the possession of “indicators of humanhood” or the lack thereof. Given the fact that anencephalic newborns are alive and are therefore persons, it is unethical to commodify them as valuable for their parts alone (Sullivan, 2003).

Although the AMA no longer condones the harvesting of organs from anencephalics prior to their death, the issue remains controversial and is therefore relevant to the application of hierarchicalism. From the perspective of graded absolutism, two conflicting ethical principles are at the root of the question of whether it is morally justifiable to use a living anencephalic newborn as an organ donor: the principles of beneficence and nonmaleficence. Adherence to the principle of beneficence compels us to help others; adherence to nonmaleficence compels us not to harm others (Munson, 2000).

With regard to the anencephalic question, empirical functionalism emphasizes beneficence, whereas ontological personalism emphasizes nonmaleficence. The desire to “redeem” the value of anencephalics by donating their organs to others in need corresponds to the “others” focus of beneficence, though it violates nonmaleficence by killing the anencephalic. Likewise, the desire to preserve the life of an anencephalic (i.e., to allow the condition to run its terminal course) follows the no-harm doctrine of nonmaleficence, though it does not come to the aid of other newborns in need of transplanted organs.

Certainly, we have a *prima facie* duty to both principles. But here, the two are at odds, requiring us to give priority to one over the other. In order to prioritize these principles, let us consider two maxims that give insight into the duties of medical practice. The first is “Above all, do no harm.” The second, from the Hippocratic Oath, is “As to diseases, make a habit of two things – to help or at least to do no harm” (cited in Munson, 2000, pp. 32 and 34). In both maxims, we see the principle of nonmaleficence (“do no harm”). In the second, although we see the principle of beneficence (“to help”), its application is qualified by the caveat, “... or at least do no harm.” There is no statement, “Above all, help others.” Rather, there is a duty to help—but not at the cost of unnecessary harm (e.g., killing the terminally ill). Thus, the principle of nonmaleficence has a basic priority over beneficence. To use the criterion of Feinberg and Feinberg, the duty of nonmaleficence overbalances the duty of beneficence (1993).

The priority of nonmaleficence is reflected in the AMA’s 1969 “Guidelines for Organ Transplantation,” which holds that there is “no justification for a relaxation of the usual standard of medical care” for a prospective donor (as cited in Lagay, 2004). This application of nonmaleficence was designed to protect the life of the donor against abuses seeking transplantable organs at any cost. Given Condit’s definition of brain death and the resulting fact that anencephalics are not dead but alive, I would extend the AMA’s 1969 guidelines to anencephalics.

One might counter this priority of nonmaleficence over beneficence by asserting that it is nonmaleficence only with respect to the anencephalic, but that it is nonetheless maleficence to the prospective organ recipients. That is, not taking the life of one within days of death seals

the fate of non-anencephalic newborns that could otherwise be saved. The principle of utility, often used to reconcile conflicts between beneficence and nonmaleficence, would assert that medical practice should maximize benefit and minimize harm (Munson, 2000). And on the surface, the aforementioned priority of nonmaleficence with respect to the anencephalic would seem to violate the principle of utility. However, this counterargument fails in its rationale, for it assumes the “greatest good” is quantifiable in terms of the number of lives saved. It fails to recognize that an even greater good is upholding the intrinsic value of an individual, regardless of the extent of deformity. *If one violates the inherent dignity of an individual to save lives, one cheapens the good of saving lives, much less the value of life itself.*

In the question of whether living anencephalic newborns should be used as organ donors, a consideration of the arguments of each side and an assessment of the underlying ethical principles within a hierarchical framework demonstrates that this can never be the morally right response. Living anencephalic newborns should not be sacrificed for organs in the name of beneficence. Rather, they should be allowed to live out the course of their lives, however short they may be, in the name of human dignity.

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