If there is to be any meaningful discussion concerning public policy, it must begin with the most basic moral value—truth. So fundamental is truth that no moral system, and indeed no cognitive discipline, would be conceivable without the basic premise that truth be assumed as a meta-principle.

The term “truth” is used in this context, not in the sense of truth-telling, but in the sense of truth-recognition. Every moral system that recognizes that, under certain conditions, communication of a falsehood is not only devoid of odium but constitutes a moral imperative. A maniac wishes to know which button, when depressed, will release a nuclear device. In that case, the morally mandated response is self-evident; in other situations the same clarity may not obtain. Truth-telling in the physician-patient relationship is a case in point. Curiously, or perhaps not so curiously, it is usually the physician who advocates full disclosure, while the ethicist may be quite prepared to clothe the lie with moral sanction. Although communication of a falsehood to another individual may be justifiable or even commendable at times, self-deception ought never be condoned. Consequently, recognition and acknowledgment of factual verities must constitute the first step in the formulation of public policy.

Organ transplants and fetal tissue research designed to preserve human life are themselves entirely unobjectionable. Yet each involves an ancillary issue posing a significant moral problem which, in current debate, has become obfuscated by confusion with regard to matters that are entirely factual in nature.

I. Legal Definitions vs. Common Parlance

Organ transplants, including the heart, lung, and pancreas, cannot be successfully performed if removal of the donor organ is delayed until cardiac
arrest occurs as the culmination of physiological deterioration. Under these conditions, tissue degeneration seriously compromises chances for successful transplantation of those organs. Transplantation of such organs is feasible only if the time at which the patient is presumed dead can be advanced to an earlier point in time. Employment of neurological criteria of death enables the patient to be pronounced dead while the heart still beats. Adopting a “brain death” standard makes transplantation of such organs possible.

The ongoing debate concerning adoption of so-called “brain death” criteria involves absolutely no controversy with regard to either factual or ontological matters. Definitions, by their very nature, are tautologies. The common-law definition of “death” as the “total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereupon, such as respiration, pulsation, etc.”\(^1\) does little more than provide verbal shorthand for statements affirming or negating the presence of those phenomena. The criteria articulated in this definition simply establish the truth-conditions which must exist in order to render the proposition “X is dead” a true statement. The truth of the statement lies in the satisfaction of the criteria, nothing more and nothing less.

The term “death” does not denote a state or phenomenon semantically distinguishable from the criteria in its definition. The term itself is descriptive, rather than prescriptive, and hence its use is entirely a matter of convention.

The theologian may speak of death as occurring upon departure of the soul from the body. If so, the theologian is making a highly significant ontological statement. If he further employs the common-law definition of “death” he, in effect, declares that “total stoppage of the circulation of blood, and a cessation of the animal and vital functions consequent thereupon” are merely the physical symptoms of a metaphysical event which cannot be perceived directly. Since metaphysical events are not subject to empirical verification or refutation, our hypothetical theologian’s assertion cannot become a subject of scientific dispute. Indeed, a logical positivist adopting the verification principle of meaning would say the theologian’s assertion is neither true nor false, but bereft of meaning. Certainly, the clinical physician, in urging adoption of neurological criteria of death, does not pretend to possess some esoteric knowledge of the perambulations of the soul which is denied to the theologian. Indeed, the physician in question may deny the existence of the soul. Whether he commits a theological,