

February 13th, 2026

Submission in response to the Australian Law Reform Commission's Review of Human Tissue Laws 2025 *Discussion Paper*

The Plunkett Centre, a research centre of Australian Catholic University, located on the campus of St Vincen's Hospital in Sydney, promotes the values of compassion and fellowship, intellectual and professional excellence, and fairness and justice, in healthcare and medical research. The Centre expresses this commitment through research, teaching and community engagement, as these as informed by the Catholic tradition.

A Our preliminary remarks

We wish to make four preliminary remarks before making two submissions about matters discussed in the Issues Paper concerning the definition of death, the determination of death and the use of the procedure called 'normothermic regional perfusion'.

In the first place, a 'nationally harmonized regulatory framework' in matters pertaining to the use of human tissues, in particular in the practices for the determination of death prior to organ retrieval for transplantation, is a good thing, so long as that harmonized framework does not come at the cost of a degradation in regulations and thus practice. What should be sought by the Australian Law Reform Commission is a good (scientifically-sound, acceptable to the community, just, reasonable, desirable, safe, etc) regulatory framework: it would hardly be 'reform' in the primary sense of 'improvement' if changes were made which degraded the regulatory framework.

Secondly, the members of the Plunkett Centre warmly support organ and tissue donation and transplantation. Indeed, one of us (Tobin) chaired the Transplant Ethics Working Party of the Australian Health Ethics Committee (a principal committee of the National Health and Medical Research Council) which issued four publications explaining and recommending organ and tissue donation in 1997.¹ It is important that the wonderfully generous life-giving

¹ Australian Health Ethics Committee (NHMRC). *Donating organs after death: ethical issues. Ethical issues in donation of organs and tissues by living donors. Ethical issues raised by*

practices of organ and tissue donation and transplantation remain true to their ethical origins, that they are matters of ‘giving and receiving’ and not of ‘taking and getting’.

Thirdly, all arrangements for organ and tissue retrieval and transplantation must adhere to the foundational ethical principle, that is, that the well-being of the potential donor takes **priority** over the benefits to the potential recipient. As the NHMRC reiterated just last year, ‘Despite the substantial potential benefits of donation for a transplant recipient, the well-being of the donor should take priority.’²

Fourthly, the Issues Paper is marred by its confusing and conflating matters which should be, and are, distinct: the definition of death, the standards for determining death, the criteria for assessing each standard, and the tests for establishing that specific criteria have been met. It is also marred by erroneously treating all forms of consciousness as something that can be directly tested for.

There is one **definition** of death: that the human organism has ceased to exist as a self-integrating whole.

There are two **standards** for determining death: the cardiopulmonary and the neurological. The cardiopulmonary standard requires the permanent cessation of circulation and respiration. The neurological standard requires the permanent cessation of the functions of the entire brain.³

Each standard has its own **criteria** for determining death. The cardiopulmonary requires the permanent cessation of circulation and respiration. The neurological requires the permanent cessation of the functions of the entire brain (including the brain stem and the hypothalamus).

There are **tests** for establishing that the specific criteria have been met. These seem to differ from unit to unit and country to country. For reasons we outline in our second submission, we recommend that these should include: for the cardiopulmonary, absent breathing, absent pulse; for the neurological, no confounding cause; coma; absent brain stem reflexes; improved tests for brain function such as testing for diabetes insipidus, confirmation of which

allocation of transplant resources. Certifying death: the brain function criterion. 1997. These documents have since been rescinded and updated ones taken their place, most recently National Health and Medical Research Council. *Ethical guidelines for all tissue and organ donation and transplantation in Australia*, 2025.

² *Ethical guidelines for cell, tissue and organ donation.* National Health and Medical Research Council, 2025

³ The use of the term ‘irreversible’, at the time the laws were passed, was understood to mean ‘lack of auto-reversal’.

would give clinicians moral certainty that all functions of the entire brain have truly ceased⁴,⁵; at least the consideration of testing for failure of the apnea test⁶.

B Our specific submissions.

Submission 1 We reject the proposed redefinition of death and support the maintenance in Australian law of reference to two ways of determining death (neurological and cardiopulmonary).

We reject this proposal to change current Australian law on the determination of death. The law should and must reflect the **objective reality** of death. A human being is dead when the human organism has ceased to exist as a self-integrating whole. The human organism has ceased to exist as a self-integrating whole when the *whole* brain has ceased to function.

Note that this **does not require** that every last neuron in the brain must cease firing before someone is declared dead: that would require awaiting the onset of putrefaction before declaring a human being to have died (and would require the abandonment of even the traditional cardiopulmonary standard for determining death).⁷ It **does require** recognition of the anatomical fact that there may be ongoing neuronal activity in someone who unresponsive, apneic and lacking in brain stem reflexes.⁸

⁴ Diabetes insipidus indicates that the hypothalamus is damaged.

⁵ There are at least three kinds of certainty. *Absolute* certainty cannot be refuted: it is self-evident or can be proven by mathematical theorems. *Empirical* certainty is the certainty that can be derived by observation, experimentation, and statistics. *Moral* or practical certainty is the certainty that can be expected of a good, well informed, and reasonable person or treating team making a decision in particular circumstances. While medical practice should be informed by available empirical evidence, most times absolute certainty cannot be reached. Instead, the standard required is moral (or practical) certainty. Moral certainty recognises that the medical or moral decision-making process can be constrained by clinical complexity, acuity, time pressures, and so on. It refers to the standard of certainty reached when a well-informed, conscientious, and clear-thinking person or treating team obtains as much relevant knowledge as possible in the time allowed in particular circumstances; reasons about possible harms and benefits; and makes a prudential judgement about what to do. This kind of certainty is necessary and sufficient for an ethically reasonable course of action.

⁶ We understand there is controversy about this administering this test, given that it puts the patient through a medical test which, if they were still alive, could precipitate death.

⁷ Jason Eberl. What is the true death of a human being? in Lisa M Rasmussen & Soren Holm eds. *Fifty years of philosophy and medicine*, Springer, 2025; p183

⁸ You will, no doubt, be aware of the circumstances in which Jahi McMath was moved from California to New Jersey, specifically, that her parents did not accept the determination of death by brain function criteria and thus had her moved to New Jersey where the law supported their rejection of the determination of death by brain function criteria (on religious grounds). You will know that she went on to live for another four years or so, on a ventilator,

We would like to explain why the proposed redefinition of death⁹ which treats a patient who is permanently unresponsive, apneic, and lacking in brain stem reflexes as dead is **deeply flawed**.¹⁰

First, this redefinition of death is **at odds with the commonsense** judgment that a patient who has significant brain function is still alive. Of course, such a patient may be gravely debilitated, and so it is possible for the substitute-decision makers to authorize the withdrawal of life-sustaining treatment and indeed to authorize that, once death has been determined, the patient's organs may be retrieved for donation to others.

Second, it is unscientific. It ignores the anatomical fact that that there may be ongoing neuronal activity in someone who unresponsive, apneic and lacking in brain stem reflexes, and thus that such a person has not ceased to exist as a self-integrating whole.

Third, it may miss important aspects of brain function. In this regard, '*[b]y only testing the brain stem and the cortex, we already may be missing important residual brain functions. The subcortical gray matter integrates arousal, motor, sensory, and autonomic functions which are intimately intertwined. Moreover, groups of neuronal and glial cells can reestablish nodes and networked patterns of activity in response to particular conditions and states of the brain. The presence of normal hypothalamic function is highly suggestive of at least thalamic functions, and failure to test for hypothalamic function thus leaves open the question of whether there is persistent subcortical cognitive function. Consciousness is not measured directly.*¹¹ *The clinical examination can only demonstrate unresponsiveness. Testing should ensure enough of the function of the brain has been lost that alternate integration pathways and connections would not sustain any form of consciousness. Codifying only the absence of brainstem and cortical functions as death dismisses important aspects of brain activity that we do not yet fully understand.*'¹²

even undergoing puberty during that time. The important point is that she clearly had not ceased to exist as a self-integrating whole when she was declared dead in California. When her parents asked for a test to be done of her hypothalamus (a part of the brain), the American College of Neurology dismissed this request. It is undeniable that she was gravely debilitated, and so, it would always have been possible for her parents to have authorized the withdrawal of life-sustaining treatment (because, for example, they might well have judged the treatment that was keeping her alive therapeutically-futile or overly-burdensome) and, indeed, to have authorized the removal of her organs for donation to someone else. That is a different matter. The basic question was whether she should have been determined to be dead In California: it seems obvious that, though gravely debilitated, she had not ceased to exist as a self-integrating whole.

⁹ In the United States it is sometimes referred to as the 'neurorespiratory' approach.

¹⁰ In significant part, the following criticisms draw on the work of Sulmasy et al. A biophilosophical approach to the determination of brain death. *Chest*, 165, No 4, April 2024

¹¹ This is a point made by the National Health and Medical Research Council in its published guidelines on the treatment and care of people with Post Coma Unresponsiveness.

¹² Sulmasy et al, *Chest*, op cit

Fourth, this redefinition of death would enshrine in law a definition of death that is **unacceptable to large parts of the Australian population**. This redefinition privileges loss of responsiveness, adding only the inability to breathe. It thus represents a quasi-higher brain standard of death which would be rejected by anyone who rejects the mind/body dualism on which it relies.

Fifth, this redefinition of death would make death a ‘**social construct**’ rather than an objective biological fact. Since so much hangs on the declaration of death (legal rights, burial, insurance matters, inheritance, marriage, organ transplantation, etc,) death ought to be treated in law as the objective biological fact that it is.¹³

Finally, because this redefinition would **generate widespread social controversy and conflict** in Australia, it would likely undermine the community trust upon which organ retrieval and transplantation uniquely depend. The already small low of organ donation in Australia would likely drop immediately if the media were to draw attention to this proposed change in the way in which death is determined (as it did in the past when some important but much more minor aspects of the process of organ retrieval were criticized publicly). There was a clear correlation between public controversy and a drop in the rate of donation.

Australian law should (continue to) say that there are two standards for determining death, a cardiopulmonary and a neurological. No weakening should be made to the cardiopulmonary standard which requires the **permanent** cessation of circulation and respiration nor to the neurological standard which requires the **permanent** cessation of the functions of the **entire** brain.

Donation after cardiopulmonary death is not only in principle justifiable: it is also generous, altruistic, indeed noble. Once again, the neurological standard does not require that every last neuron in the brain must cease firing before someone is declared dead: what it does require is that important aspects of brain function are not missed or dismissed.

Submission 2: We reject the proposal that normothermic regional perfusion should be permitted.

The Issues Paper describes NRP as a technique used in the removal of organs from donors after death who do not meet the test for brain death (page 49). It goes on to note two types of NRP, abdominal NRP, where blood is circulated to the abdominal organs such as the kidney, liver and pancreas, and thoracoabdominal NRP, where blood is also circulated to the heart and lungs. The Issues Paper then goes on to list several benefits of NRP, to mention that the legality and ethics of NRP have been debated, to set out (and to agree with) the position of ANZICS and thus to ‘open the door’ to the use of NRP (to be done in accordance with ‘accepted medical practice’).

¹³ Smolensky KR. Rights of the dead. *Hofstra Law Review*, 2009:371(3); 763-803. As referenced in Sulmasy et al. *Chest*, op cit.

We reject this proposal. Given that at least thoracoabdominal NRP involves ligating the arteries that provide blood to the person's brain **in order to occlude cerebral circulation**, the American College of Physicians in 2021 described NRP as a technique **'to bring on brain death'**. The purpose of the thoracoabdominal procedures is to ensure that neurological function will not resume. **'The evident intentionality underlying this practice is to violate the DDR [Dead Donor Rule] by bringing about the cessation of neurological function...'** ¹⁴ Given that circulatory function is restored, cessation of circulation was neither irreversible nor permanent. **'Arguing that this patient was already declared dead wilfully ignores that this declaration is now proven mistaken.'** ¹⁵ Other forms of NRP require something more than the agreement of the small part of the medical profession which understands them. They require much more robust public scrutiny.

Organ donation is a generous and life-giving gift, not only ethically justifiable but ethically desirable. The real ethical issues lie in how it is done. The devil is in the detail. In this regard, as in much else, we support the submission from St Vincent's that the criteria for determining whether one or other of the two standards for determining that death has taken place must be open to public scrutiny and not left to a small part of the medical profession who truly understand the issues. We must not allow the pressure to retrieve organs for transplantation to lead to fudged definitions (for example, with respect to the definition of death) or to unethical practices ('determining' someone with significant brain function to be 'dead').

We are grateful for this opportunity to make a submission to your deliberations and would be happy to answer any questions you may have.

With best wishes,

A black rectangular redaction box covering the signature of Dr. Xavier Symons.

Dr Xavier Symons
Director

A black rectangular redaction box covering the contact information of Dr. Xavier Symons.

Dr Bernadette Tobin
Researcher

¹⁴ American College of Physicians, 2021. Ethics, Determination of Death, and Organ Transplantation in Normothermic Regional Perfusion (NRP) with Controlled Donation after Circulatory Determination of Death. As quoted in Jason Eberl. *op cit*. See also Matthew DeCamp, Lois Snyder Sulmasy, Joseph Fins. Does normothermic regional perfusion violate the ethical principles underlying organ procurement? *Yes*. *Chest*, August 2022: p 288-290v

¹⁵ Editorial. *Journal of Cardiothoracic and Vascular Anaesthesia*, 38 (2024); 608-609