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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.

In a previous issue of this journal, Alireza Bagheri supports a policy on organ procurement based in a form of pluralism in the definition of death.¹ Bagheri's paper aims to enhance both organ procurement and respect for personal autonomy by "allowing individuals to choose under which condition they wish their death to be pronounced." Medicine alone, he says, "cannot show whether a brain-dead patient is 'alive' or 'dead,'" because there is no consensus on the definition of death and because defining death is not merely a medical question but also a matter of philosophical and cultural beliefs. Bagheri argues that, in order to prevent any possible violation to potential donors' rights, the decision over the definition of death should not ignore individual autonomy. However, to avoid public chaos, the author limits individual's discretion to two socially accepted alternatives: whole-brain death and cardiorespiratory death criteria. "Bizarre" alternatives, such as higher-brain death, must be rejected if they are not "socially accepted standards." According to him, such a policy might increase public confidence in the organ procurement system and promote voluntary organ donation. He defends the case of Japan as the country whose policy on organ procurement is closest to the pluralism on the determination of death that he supports. We find issue with Bagheri on two counts.

First, Bagheri's argument implies that distinguishing bizarre arguments from socially acceptable ones is relatively straightforward at any point in time. Yet, he contradicts himself by claiming at one point that a conscience clause could allow persons "to choose only a single [extra] definition among socially accepted alternatives"—in this case cardiopulmonary death instead of the default brain death. At another point, he cautions against a system (our current one) in which "societal interests in a convenient uniform definition outweigh individual choice." Since Bagheri seems to identify "socially acceptable" with "socially accepted alternatives," we might ask what is for him the difference between "socially accepted alternatives" on one hand and "societal interests" on the other. Use of the term "bizarre" to identify the definitions society could

rule out as unacceptable hardly does the difficult work of resolving value disputes in a pluralistic society. Moreover, this lack of any criterion to distinguish acceptable from unacceptable definitions easily leads to slippery slopes. According to Bagheri:

If some day higher brain criteria or any other alternative definitions become an accepted definition for human death for most of society and applicable by law, the position of this paper is still firm and would advocate people's right to choose among those two, three or more alternatives.

However, not all accepted alternatives are necessarily acceptable. Let us think on a future where irreversible dementia would have become for a significant part of society equal to death. Would it be acceptable that a conscious but irreversibly incompetent Alzheimer patient is dead if he had previously decided to be considered dead? Would a "dementia criterion" of death be less "bizarre" if it was socially accepted? Would this scenario avoid what Bagheri calls "public chaos"? Without some firm boundaries, Bagheri's socially grounded pluralism fails to be the safe policy course he is looking for. The controversy and lack of consensus on the definition of death show that, up to now, biology alone cannot afford such a boundary, especially in borderline cases, such as brain death or PVS. However, it does not mean that biology has nothing to say.

Our second concern with Bagheri's (and Robert Veatch's²) policy solution is that relying on personally determined definitions of death to solve the organ shortage depends on a fiction that constantly moving the line between life and death—by the state or individuals—is good social policy in that it increases both organ donation and public trust. We are not so sure. By allowing multiple definitions of death, we simply pretend that we are not violating the dead donor rule.³ Many people, including professionals, do not assume that a donor must be dead in order to donate vital organs.⁴⁻⁶ Would it not be more productive of social trust to have honest public discussion about the circumstances under which the dead donor rule could be violated? In 1968, the Harvard Committee⁷ suggested that so far legally alive patients in "irreversible coma" be considered dead so that turning off their ventilators or taking their organs could not be construed as murder. Since then, there has been a robust social discussion about the moral circumstances under which ventilators may be discontinued not only from brain-dead patients but from all patients. Here, the law and medical ethics have relied on autonomy—personal choice—to decide when the burdens of high technology outweigh the value of life. The social discussion has been deep, heated and productive. The outcome is clear: competent adults have a legal and moral right to refuse life-sustaining mechanical ventilation. By honouring patient autonomy and assuring no

harm to patients, we anchor ourselves from sliding down a slippery slope. We believe personal values make more sense for deciding when to end a severely compromised life than they do for deciding the semibiological question of when death occurs in an intensive care unit. We suggest that informed consent could be the cornerstone of an ethically sound organ procurement policy beyond the dead donor rule in situations where the patient is clearly beyond harm. Of course, critics will accuse us for advocating “killing” patients for their organs. Are we? Perhaps yes. Perhaps no. For certain, we are not avoiding a discussion about whether increasing the supply of organs should permit euthanasia under the right moral circumstances.

Competing interests: None.

REFERENCES

1. **Bagheri A.** Individual choice in the definition of death. *J Med Ethics* 2007;**33**:146–9.
2. **Veatch RM.** The conscience clause: how much individual choice in defining death can our society tolerate? In: Youngner SJ, Arnold R, Schapiro R, eds. *The definition of death: contemporary controversies*. Baltimore: The Johns Hopkins University Press, 1999:137–60.
3. **Robertson JA.** The dead donor rule. *Hastings Cent Rep* 1999;**29**:6–14.
4. **DuBois JM.** Ethical assessments of brain death and organ procurement policies: a survey of transplant personnel in the United States. *J Transpl Coord* 1999;**9**:210–18.
5. **Herpin N,** Paterson F. Le don d'organes et la perception de la mort par les Français: les systémistes et les intégralistes. In: Carvais R, Sasportes M, eds. *La greffe humaine*. Paris: PUF, 2000:789–814.
6. **Siminoff LA,** Burant C, Youngner SJ. Death and organ procurement: public beliefs and attitudes. *Soc Sci Med* 2004;**59**:2325–34.
7. **Anon.** A definition of irreversible coma. Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. *JAMA* 1968;**205**:337–40.