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Abandon the Dead Donor Rule or Change the Definition of Death?

ABSTRACT. Research by Siminoff and colleagues reveals that many lay people in Ohio classify legally living persons in irreversible coma or persistent vegetative state (PVS) as dead and that additional respondents, although classifying such patients as living, would be willing to procure organs from them. This paper analyzes possible implications of these findings for public policy. A majority would procure organs from those in irreversible coma or in PVS. Two strategies for legitimizing such procurement are suggested. One strategy would be to make exceptions to the dead donor rule permitting procurement from those in PVS or at least those who are in irreversible coma while continuing to classify them as living. Another strategy would be to further amend the definition of death to classify one or both groups as deceased, thus permitting procurement without violation of the dead donor rule. Permitting exceptions to the dead donor rule would require substantial changes in law—such as authorizing procuring surgeons to end the lives of patients by means of organ procurement—and would weaken societal prohibitions on killing. The paper suggests that it would be easier and less controversial to further amend the definition of death to classify those in irreversible coma and PVS as dead. Incorporation of a conscience clause to permit those whose religious or philosophical convictions support whole-brain or cardiac-based death pronouncement would avoid violating their beliefs while causing no more than minimal social problems. The paper questions whether those who would support an exception to the dead donor rule in these cases and those would support a further amendment to the definition of death could reach agreement to adopt a public policy permitting organ procurement of those in irreversible coma or PVS when proper consent is obtained.

Laura Siminoff, Christopher Burant, and Stuart Youngner (2004) have made clear that substantial confusion and disagreement exists among the citizens of Ohio over the definition of death and

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when organs for transplant can be procured. The cases presented in their survey involved (1) a patient who had lost all functions of the entire brain (Scenario 1: the "brain death" case), (2) an irreversibly comatose patient on a ventilator with no possibility of recovery of consciousness (Scenario 2: irreversible coma), and (3) a patient breathing without mechanical support who had no possibility of recovery of consciousness (Scenario 3: the PVS case). Responses to these three cases from more than 1300 Ohio residents show not only that the respondents apparently often misunderstand the Ohio law regarding the definition of death and organ procurement, but also that their moral intuitions appear significantly inconsistent with that law. A majority was wrong in their belief about whether someone with a dead brain was legally dead. On the other hand, a majority was willing to claim that the comatose person was really dead, and, in spite of enormous publicity about famous patients in persistent vegetative state—such as Karen Quinlan—being alive, a large minority (34%) considered such a person dead.

Youngner and others have documented how physicians and nurses were similarly confused and in disagreement about the status of patients with dead brains or severe brain pathology. In 1989, using a somewhat different method, he and his colleagues found that only 35 percent of respondents within the health professions correctly identified the legal and medical criteria for determining death (Youngner et al. 1989).

The Ohio study by Siminoff and colleagues also shows that one third of the respondents is willing to donate the organs of at least some humans considered alive, at least when presented with a hypothetical scenario. That is, they are willing to condone killing them to get their organs. They would, in short, be willing to break the "dead donor rule" (DDR), which holds that one cannot licitly procure life-prolonging organs from a donor until that donor is dead. To procure when the organ source is still alive would kill the donor. It would be a homicide, and even the explicit permission of the donor does not legally justify a homicide. The present study thus raises the question of whether a rule that is near sacrosanct in the transplant community can be supported if there is such a large minority who reject it. Moreover, Siminoff and her colleagues also found that a very large percentage (about 95%) were willing to procure life-prolonging organs from legally living comatose and vegetative patients when they were mistakenly classified as dead. This represents a second group that would, in effect, break the DDR because they were mistaken about classifying legally living patients as deceased.

The apparent confusion among lay people and health professionals over the definition of death and the DDR raises provocative questions not only for clinicians and policymakers, but also for theoreticians who have analyzed the definition of death and placed substantial weight on the DDR (Arnold and Youngner 1993). Recent scholarship has called that rule into question (see Koppelman 2003 and fifteen accompanying commentaries on the subject).

The massive confusion suggests that the dominant policy requires further examination. On the one hand, the existing definition of death is called into question. The legal policy of insisting on loss of all functions of the entire brain before death is pronounced seems to be rejected by a majority. On the other hand, the importance of the dead donor rule also is challenged. The insistence on death prior to procurement of life-prolonging organs does not seem important to many of these Ohioans. The data might suggest that a significant number of people (again, about one-third) would want to abandon the DDR in at least some cases.

Although one might be tempted to reach these conclusions from the data, I do not think they reflect the only possible interpretation—or even the most likely. I will argue that the data, in fact, are consistent with a policy that would retain the DDR and modify the definition of death so that life-prolonging organs could be procured from some deceased persons who retained certain brain functions. I will further suggest that the data support shifting to a pluralistic definition of death, what sometimes is referred to as a "conscience clause," that would permit people to choose their own definition of death from within a range of socially acceptable options. Although the data are insufficient to support this final proposal fully, I will suggest that the data are supportive and that a rather modest amount of additional research would clarify the question.

AMBIGUITIES IN THE DATA AND ITS INTERPRETATION

Before turning to the interpretations of the data and their implications for the definition of death and the DDR, one needs to be clear about exactly what the data show.

Are Legally Dead People Alive?

The most serious issue is to clarify exactly what respondents are saying when they tell researchers that, in the three scenarios, the patients are either alive or dead. The study reports that 13.8 percent considered the patient with a dead brain (Scenario 1) to be alive. This is quite consistent

with the standard wisdom that about 10 percent of the U.S. population holds a cardiac-oriented definition of death or its approximate equivalent. Thus, these respondents could misunderstand the Ohio law, but, alternatively, merely could be stating that they disagree with it. The study also reports that 57.2 percent of the respondents considered the comatose person who retained some brain activity (Scenario 2) to be dead, and that 34.1 percent considered the PVS patient breathing on his own to be dead (Scenario 3). All of these responses are inconsistent with Ohio law, suggesting once again that these respondents either do not understand the law or disagree with it. It is not clear whether the respondents are telling the interviewer that they think these people are dead or alive according to the law or whether they think them truly to be dead or alive (regardless of the law).

The present author faced a similar problem when serving as an expert witness on behalf of the mother in the Baby K case—the case of a permanently unconscious anencephalic infant with enough brain function to breathe, intermittently, on her own and whose mother wanted to continue aggressive life-support). The attorneys for the hospital asked in deposition whether I considered Baby K to be alive or dead. Knowing that I had for many years defended a "higher-brain" definition of death that would make spontaneously breathing anencephalics—and the PVS patient in Scenario 3—dead (Veatch 1975), they hoped I would state the baby was dead at which point they would have asked me if I believed that dead people should receive "life-support." Had I said that the baby was dead, they would have forced me to acknowledge that dead people have no right to be treated, but had I said the baby was alive, they would have accused me of being inconsistent with my long-established views.

My response was that Baby K—and all other anencephalics and PVS patients who retain residual brain functions—were deceased according to my own views, but according to state law, they were alive. I further asserted that the state must therefore treat the baby as alive, at least until it changed its law.

Possible Interpretations of Responses

It is possible that the respondents in the Ohio study who were asked whether various patients were dead or alive faced a similar problem. Only 33.7 percent responded that persons with dead brains were dead persons although when presented with a scenario of a "brain-dead" person, 86 percent thought that person was dead. One could speculate that some

people undoubtedly believed that "brain-dead" persons (Scenario 1) were alive in spite of knowing that the law in Ohio classified them as dead. Likewise, some may have believed that irreversibly comatose persons with residual brain functions (Scenario 2) and PVS patients (Scenario 3) were dead in spite of the fact that they knew Ohio law classified them as living.

Just as I stated in court that I believed Baby K to be legally alive in the state of Virginia, even though I thought the law was wrong, so some of the study respondents may have claimed, based on their personal opinions, that the patients in Scenarios 2 and 3 were dead even though they knew that they were legally alive.

DO RESPONDENTS ENDORSE VIOLATING THE DEAD DONOR RULE?

Setting aside the problem of whether the respondents were reporting whether they believed the law classified the various persons as dead or, alternatively, they themselves classified these persons as dead, can one conclude from the data that many respondents are open to abandoning the DDR?

What Do the Data Suggest?

There is apparently much less emphasis among respondents on the DDR than professionals in the field would expect. In the "brain death" scenario (Scenario 1), two-thirds of the small group who considered the patient alive would violate the DDR. This could, of course, merely reflect the respondents' confused understanding of the law. If they believed that the law classified the "brain-dead" person as alive, but simultaneously saw nothing wrong with treating such a person as dead, the respondent might appear to be forced into the position of endorsing a violation of the DDR. The respondent actually could be saying that he or she does not object to procuring organs from people who are "really dead" even though the respondent mistakenly believes the state classifies these people as alive. (This explanation gains plausibility when one notes the level of confusion about the current law. Only one-third thought these people legally were dead.) The alternative is that this group (who believed the "brain-dead" person was alive but nevertheless endorsed the taking of organs) really believes in violating the DDR.

In the irreversible coma scenario (Scenario 2), almost half of those who thought the patient was alive nevertheless would support organ procurement, and even in the PVS scenario, about one-third of those who thought the patient alive would support procurement.

These constitute sizable minorities in each case who say they would violate the DDR. (In fact, in the small group who told researchers that the "brain-dead" person was alive, a majority would violate the DDR, although I do not see how one can rule out that the respondent was merely mistakenly stating that he or she believed the state classified the patient as alive.)

What Are the Implications for the DDR?

First, with the possible exception of the small group in Scenario 1 who believed the patient was alive, the majority of respondents gave responses consistent with the DDR. Thus one could say that there was more support for than opposition to it. There is a second question, however, that the data cannot answer. Would those who appear to be willing to violate the DDR also be willing to accept a change in the definition of death so that the DDR can be preserved?

Changing the Definition of Death and Preserving the Dead Donor Rule

The relationship of the dead donor rule to the definition of death is complex and not always well understood even by experts in the field. Consider the position of those who believe that organs should be procured from irreversibly comatose persons who still have some residual brain function or from those in a persistent vegetative state. Such patients currently are classified as alive according to the law in Ohio and all other jurisdictions of the world. Those who conclude that life-prolonging organs can be procured from these people could formulate their position in two quite different ways.

One strategy has been proposed by some defenders of organ procurement from anencephalic infants (American Medical Association 1995; *In re T.A.C.P.* (Baby Theresa) 609 So. 2d 588 (Fla. 1992); cf. Committee Reports: Ethics 1995), irreversibly comatose patients, and those in a persistent vegetative state. These advocates propose "exceptions" to the DDR to cover such cases. They would procure from special groups of persons classified as living. It seems that this would be the position of at least some of those who responded to Scenarios 2 and 3 by saying that the patient was alive but nevertheless that organs could be procured. Call this "Option 1."

A second strategy, however, would lead to the same policy of procuring organs from these categories of patients by changing the definition of death so that people in these groups were considered dead and treated accordingly. Call this "Option 2."

The Historical Analogy

The problem is precisely analogous to public policy debate of the late 1960s. When organ transplant became feasible and clinicians and theoreticians realized that some living people were being maintained in hospitals without functioning brains, it was inevitable that someone raise the question of whether organs could be procured from these people without the nicety of waiting until their hearts stopped irreversibly. One strategy (Option 1) would have been to propose exceptions to the rule that the organs could not be removed until the individual was pronounced dead. Although some considered that strategy, the winner was Option 2: change the definition of death so that these people with dead brains could be pronounced dead a bit earlier. Option 2 rather easily won widespread support.

The Harvard Medical School Ad Hoc Committee (1968) chaired by Henry Beecher unanimously supported a new definition of death. The striking thing about the committee's report is that in no place does it bother to defend the claim that people with dead brains should be classified as dead people.

As a graduate student at Harvard interested in medical ethics, I worked closely with several of the members of the Ad Hoc Committee, including Henry Beecher, its chair, and Ralph Potter, the theological ethicist on the committee. None of the members was so naive as to believe that people with dead brains were dead in the traditional biological sense of the irreversible loss of bodily integration. (Some may have made the logical and empirical mistake of assuming that people with fully dead brains are dead because they are inevitably soon to experience death in the traditional biological sense, but some committee members understood that the predicted loss of this bodily integration in the near future did not prove that the individual with a dead brain already was dead.[1]) Rather, committee members implicitly held that, even though these people are not dead in the traditional biological sense, they have lost the moral status of members of the human moral community. They believed that people with dead brains no longer should be protected by norms prohibiting homicide—even merciful homicide with the consent of the one killed. In effect, the committee and its fellow travelers proposed an entirely new definition of death, one that assigned the label "death" for social and policy purposes to people who no longer are seen as having the full moral standing assigned to other humans.

This then new definition of death thus ceased to have inherent biological meaning, but rather embodied a moral meaning. The committee mem-

bers identified a group of humans deemed to have undergone a quantum change in moral status and called them "dead." This signaled that such persons would stand in a new relation with the moral community. Among the implications would be that organs that normally preserve life could be removed without the elaborate moral defense normally necessary to justify a homicide. Once one is labeled "dead," mere advance approval of the individual or of a valid surrogate routinely would justify removal of organs that normally would preserve life. The person with a dead brain would be treated the way dead people are treated.

I suggest that the project of the past 30 years has been one of attempting to figure out which humans with bodies containing living tissue may be treated the way we normally treat dead people. Among the implications would be that these people can have organs removed without the elaborate justification that would normally be required to justify a homicide. Once we have figured out which people qualify for this new moral status, we will assign a name to this new category. For better or worse, the name we chose at the time was "dead."

The group from whom life-prolonging organs can be taken without special justification of homicide are thus "dead" by definition. We first identify the group and then label them with the name. The name, unfortunately, is the same name we used to apply to those who have experienced biological death. This is not the first time that the same English language word has taken on two completely different meanings. It often leads to linguistic confusion, but this is the nature of language. Even within biomedical ethics, words like "person" are known to have at least two quite distinct and importantly different meanings. Some define "person" morally to refer to "any being with full moral standing," while others define it nonmorally to refer to beings with self-awareness or self-consciousness. It is no wonder that confusion reigns when conservatives on abortion claim that embryos are "persons" (meaning have full moral standing), while liberals claim that embryos and even fetuses are obviously not "persons" (meaning have self-awareness or self-consciousness).

For many years, I have argued that picking a definition of death is a matter of determining moral standing (Veatch 2000) and that the DDR is true "by definition" (Veatch 2003). I now realize that I have not been careful enough in putting forward this thesis. What I have meant by the definitional claim is that, if one wants to procure life-prolonging organs without the normal rigorous requirements to justify a homicide, then one must procure them from humans who have undergone the quantum change

in moral status I have been discussing. It is this group that is called "dead" by definition.

Of course, such organs theoretically may be procured from humans who are not in the category of the dead, but the defense of that practice would be difficult. Two groups of humans classified as alive have been proposed as potential organ sources: prisoners condemned to capital punishment and rationally suicidal individuals. Such condemned prisoners already may have served as organ sources in China. People have speculated whether the Chinese have forced prisoners to serve as organ sources or whether those prisoners have volunteered for the role (Rothman et al. 1997; Briggs 1996). Regardless, it is clear that such procurement would be very controversial and would require elaborate justification. An exception would have to be created to the homicide laws to avoid having the surgeon accused of murder. In Western culture, even voluntary donation of organs by a condemned prisoner has never been acceptable. In 1978, I corresponded with a condemned prisoner named Johnny Evans, sentenced to death in Alabama. We published his request to be an organ donor in the *Hastings Center Report* (Bedau and Zeik 1979). Such procurements never have been considered acceptable. In effect, the DDR has held.

Likewise, obtaining organs from suicidal persons is very controversial and has never been endorsed. Clearly, many suicides are committed by persons suffering from mental illness that would make their organ offering nonvoluntary. It is conceivable, however, that some suicides are "rational." They are committed by people who understand what they are doing and consider their future lives not worth living. Some see these so-called "rational suicides" as a source of organs. (Jack Kevorkian is known to have begun exploring suicide in the terminally ill because of an interest in eventually being able to get transplantable organs from some suicidal people.) Once again, however, almost no one finds these cases plausible. Organ procurement from those classified as living would require complex moral argument and laws establishing justifiable homicide. By contrast, procurement from individuals classified as dead is a relatively simple matter, merely requiring permission from the deceased or next-of-kin. In this sense, the DDR can be said to be "true by definition." One first identifies the groups of humans who have undergone a radical change in their moral standing so they no longer are considered members in full standing of the moral community and then defines that group as dead.

I think it is reasonable to say that is *de facto* what happened in the 1970s to reclassify those people with dead brains as dead.

The Choice

Now the question arises of whether we wish to adjust the categories a bit more so that organs could be procured from those who retain some brain function but are irreversibly comatose or persistently vegetative. Again we are faced with a choice between Option 1, making an exception to the DDR so that organs could be procured from certain carefully defined groups of living people, and Option 2, further amending the definition of death to reclassify irreversibly comatose, and perhaps persistently vegetative, patients as "dead."

The Ohio data suggest that some Ohioans think each way. One group's responses are consistent with Option 1. They respond as if they want to make exceptions to the DDR. They want to treat these patients as alive, but nevertheless support procuring organs from them. Of those whose data were presented, two-thirds of those who classified the "brain-dead" person as alive would procure organs (125 people); 46 percent of those who accept the irreversibly comatose patient as alive still would procure organs (264 people); and 34 percent of those who accept the PVS patient as alive would do so (305 people). Their responses are, in effect, consistent with supporting an exception to the DDR.

On the other hand, 739 respondents would call the legally alive, irreversibly comatose person dead and approve of taking organs, and 435 would call the PVS patient dead and approve of taking organs. Thus, in terms of shear numbers, of those who would take organs from people presently classified legally as alive, more people gave responses consistent with the strategy of holding firm to the DDR and revising the definition of death rather than holding firm on the definition and permitting exceptions to the DDR. The overwhelming majority now accepts the revised definition when it comes to those with complete loss of all functions of the entire brain (the "brain-dead"). Likewise, an absolute majority of the sample (739 people) classify the irreversibly comatose as dead—although a sizable minority (264) would hold to a more traditional death definition and nevertheless procure organs. Even in the case of the PVS patient where only a small majority favors procuring organs, more favor doing so by classifying the person as dead than by creating an exception to the DDR.

How Firm Are the Positions?

If this were strictly a majority rule issue for the citizens of Ohio and if the sample truly represented the voters, the support seems to favor the

view that organs should not be taken from people who are classified as alive, but shifting from the now traditional whole-brain definition of death, which would include only Scenario 1, to a higher-brain definition of death, which would cover the other two scenarios as well. It seems clear, however, that most typical respondents never really confronted the question of choice between these two options. I suggest, however, that it is likely that the respondents were more firm in their opinions on whether to procure organs than on whether to change the definition of death or, alternatively, make an exception to the DDR. The question for one trying to craft a consensus is how strongly the members of each group—those who support Option 1 or Option 2—are committed to the explanation of why they support donation and whether either (or both) of the groups could be persuaded that the other option would be acceptable. For example, since they are a smaller group, could those who would retain the current definition of death and make exceptions to the DDR come to view a further change in the definition as an acceptable alternative?

As I have suggested, it seems plausible that the respondents may be more firm in their conviction that organs can be procured than they are in whether the people in Scenarios 2 and 3 are dead or alive. The latter question is one that most have not thought about previously, and they probably are not conceptually equipped to understand the options. Most critically, they probably have not had an opportunity to think through the implications for a range of other social practices unrelated to transplant that depend on definition of death. For example, if exceptions are made to the DDR, many other social and legal changes would be required in order to bring practices in line.

Most conspicuously, there would have to be a change in all homicide laws so that surgeons who, with proper consent, remove organs would not be guilty of murder. Similarly, one reason that society moved in the 1970s to amend the definition of death rather than to make an exception to the DDR probably was related to the abortion debate. Those who oppose abortion fear that making an exception to the prohibition on homicide would weaken prohibitions on taking human life, which, in turn, would weaken resistance to abortion. Adding exceptions to the prohibition on homicide might make it easier to make further exceptions. They want to draw a sharp line at excusing homicide only in self-defense or perhaps capital punishment—both exceptions implying guilt or aggression by the one being killed. That charge would be terribly implausible if brought against a fetus.

Hence, the approach of creating exceptions to the DDR found resistance among the half the population that opposed abortion. They felt that changing of the definition of death did not pose a similar threat since death always implies an irreversible loss of functioning, something that does not apply to any normal fetus.

Looking at the responses to the scenario involving the irreversibly comatose, 739, a majority of the entire sample, would procure organs when believing the patient was dead, while 264 would procure while maintaining the patient was alive. The question remains whether the larger group, who supports organ procurement while considering the patient dead, could be persuaded to accept the alternative of retreating to a more traditional definition of death while making exceptions to the DDR. One gets the impression that many of the respondents who favored procurement in Scenarios 2 and 3 probably were not irrevocably attached to either position. Additional data on the question of whether they could be persuaded to go the route of making exceptions to the DDR would be helpful. One thing seems clear from the data: there is an absolute majority in favor of procuring organs from irreversibly comatose and PVS patients who have not experienced total loss of all brain functions and, hence, who are not presently classified as dead by Ohio law.

Attempting to develop a consensus for creating exceptions to the DDR poses some serious problems in addition to the need to persuade more people and to amend the homicide law. One is that the approach of creating exceptions to the DDR could take either the whole-brain death position as its starting point—adding irreversible coma and PVS as the two exceptions—or it could retreat back to the earlier cardiac-oriented definition, creating exceptions to the DDR for those with the death of the whole brain as well as those who are irreversibly comatose and persistently vegetative. Theoretically, the latter strategy probably makes more sense. There has been increasing doubt about the whole-brain position (Halevy and Brody 1993; Shewmon 2001; Veatch 1993). A cleaner approach for one inclined to hold firm on the definition and tamper with the DDR would be to go back to a somatic integrating or cardiac-oriented definition of death and then establish total absence of brain function or severe brain pathology, including irreversible unconsciousness, as exceptions to the DDR.

That more logical approach, however, would create some serious practical problems. Great effort has been exerted in the past 30 years to get brain-based definitions of death adopted in every jurisdiction of the United States and in almost all countries of the world, as well as to try to con-

vince physicians and lay people to use language consistently—to quit talking about the possibility of preserving the lives of "brain-dead" people, for example. We would have to repeal all the brain death statutes and get health professionals and lay people to unlearn the brain-based definitions of death they are beginning to accept, as indicated by the overwhelming acceptance of respondents that the person in Scenario 1 is dead. Then we would have to adopt laws creating the exceptions to the homicide laws that would permit organ procurement from some living people. Since many other social behaviors are linked to classifying people as dead or alive, we would have to figure out whether the same exceptions that are created to the DDR also should be made for these other death behaviors. We would have to determine, for example, whether living persons with dead brains, irreversible coma, or PVS still should be covered by health insurance, whether their life insurance should pay off at the time these living people become DDR exceptions (even if they do not donate organs and continue having bodily functions supported), whether their spouses should be treated as widows and widowers while the permanently unconscious, brain damaged person is still alive, and so forth. With the present change to a brain-based definition of death, and with potential further changes, it is clear that once one is pronounced dead our social practices regarding all, or at least most, of these other behaviors would follow. With the alternative of creating exceptions to the DDR, presumably none of these changes necessarily would follow just because society would tolerate homicide by organ procurement should the proper consent be obtained. Society would have to decide whether it wanted changes in all these areas as well and enact legislation accordingly. In an environment in which a large part of the population has a strong interest in not changing any of the rights of the living to avoid being killed, all of these battles would be hard fought and contentious. Holding firm on the homicide, insurance, marital, and organ procurement laws seems much the wiser course. That would mean siding with the majority of Ohioans and making further changes to the definition of death while sticking to the DDR.

THE DATA AND THE CONSCIENCE CLAUSE

The patterns of disagreement, ambiguity, and confusion seen in the data have important implications for another major issue. Exactly what those implications are cannot be known for sure without further data. It is overwhelmingly clear that people differ significantly on how many of the three hypothetical people in the scenarios are dead. About 216 people

considered the "brain-dead" person alive; 399 accepted the current law that viewed only "whole-brain death" (Scenario 1) as death; 403 thought the people in all three scenarios were dead; the balance (about 333) must have viewed at least one, but not necessarily the other, of the irreversibly comatose and PVS patients as dead. In other words, none of these positions commands anything like majority support. This result is consistent with findings during the past 30 years (see Charron 1975 for similar data regarding the views of citizens of Missouri). To make the picture more complex, it seems likely, as I argued in the previous section, that many of the respondents who classified some of these persons as alive and nevertheless believed it was acceptable to procure organs from them could be persuaded to adopt the alternative strategy of calling such persons from whom organs could be obtained "dead people" thus shifting them into one of the other camps.

The picture is one of several different positions, all somewhat plausible, but each with its defenders unlikely to be able to convince enough others to make their position a majority. The single most crucial piece of data not measured in the study is how likely various respondents would be to be satisfied if terminal care and death pronouncement decisions were made in their own cases based on their own definition of death even though others were not forced to have the same death definition used on them. For many years I and others have endorsed a "conscience clause" for the definition of death that would see a state adopt a default definition, such as "whole-brain death," and then permit individuals (and probably their valid surrogates) to opt for an alternative definition that is within reason. They would, in effect, be permitted to choose any definition as long as people who had heart, lower-brain, and higher-brain function were considered alive and those who had lost all of these functions were considered dead. For example, would those who accept organ procurement in Scenarios 2 and 3 be content if they could be pronounced dead and donate their own organs—or the organs of their loved ones who had not expressed their own views—when irreversible coma or PVS occurred with the proviso that those who accepted "whole-brain death"—i.e., death only in Scenario 1—could be treated as living until "whole-brain death" (or "cardiac-based death") occurred?

Since no one is obligated to donate organs, presumably the "liberals" who favor a version of "higher-brain death" would not object to such a policy. Likewise, would those who favor "whole-brain death" be willing to accept the authority of the proponents of "higher-brain death" to choose

that definition of death for themselves and for those for whom they have decisional authority? Since these people presently have the right to forgo life support and thus will be dead at about the same time in any case, it could be that many defenders of "whole-brain death" would not object to letting the proponents of higher-brain views have their preferred definition. It would have little bearing on when death occurs. It could, however, produce what defenders of "whole-brain death" would see as an intentional active killing—an intentional, voluntary homicide—if organs were removed while they considered these persons alive.

The key unanswered question is whether the defenders of more conservative views on the definition of death would show tolerance for those who choose to have a more liberal definition used in their own cases. The law would treat organ procurements in these cases as procurements from deceased individuals, not as exceptions to the DDR. Consequently, that which, from the point of view of the proponent of a higher-brain definition of death as well as the law, would be a legitimate procurement from the deceased would be, from the conservative's point of view, a killing. Given that the Ohio survey found that a significant minority already appears willing to violate the DDR and, so, to tolerate killings, one could speculate that the holders of the more conservative positions would not object to individual discretion in picking a definition of death, especially since they would never be forced to act in a manner that violated their own understanding of what was acceptable. More data on the attitudes of people about a conscience clause and the behaviors of those who exercised such a clause would be crucial in deciding how the citizens of Ohio can work their way out of the bind they are in, in which the majority of those surveyed do not support the current laws regarding the definition of death and organ procurement and no consensus seems to be suggested from the responses.

NOTE

1. Recently, it has become increasingly clear that the belief that bodily integration inevitably would be lost soon after the brain dies is not accurate. Several have pointed out that persons with dead brains may retain integrated bodily functions for a long time—perhaps years (Shewmon 2001).

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