Theor Med Bioeth (2017) 38:229–233
DOI 10.1007/s11017-017-9400-5

Franklin G. Miller and Robert D. Truog: *Death, dying, and organ transplantation: reconstructing medical ethics at the end of life*

Oxford University Press, 2012, 196 pp, ISBN: 978-0199739172

Susanna Maria Taraschi[1]

Published online: 25 February 2017

Modern medicine has improved to ever higher levels in its capacity to preserve life through the enhancement of its intensive care structures and the possibility of organ transplantation. But, at the same time, these practices have brought the risk of forgetting and/or obfuscating the basic principles of medical ethics, which, first of all, prescribe that clinicians must not kill their patients and that vital organs can be removed only from *dead* human beings. This is the main issue that the authors present in the Preface of the book, and it is useful for understanding the ethical importance of the book's reflections. The final aim of the authors, in fact, is to preserve the legitimacy of end-of-life practices by reviewing and evaluating its medical ethics.

Chapter 1 deals with a very delicate topic: the withdrawing of life-sustaining treatments. The issue is crucial because it entails an unavoidable reference to the theme of euthanasia. Observing that the advent of the mechanical ventilator and other intensive care practices in the mid-twentieth century has obliged medicine, ethics, and law to face new problems, the authors examine in depth the question of withdrawing life-sustaining treatments (LST), analyzing the concepts of 'death' and 'killing'. The chapter argues very well the thesis that 'the clinician who withdraws LST in accordance with the valid consent of the patient or a surrogate deciding on an incompetent patient's behalf, causes the patient's death' (p. 3). In their argument, the authors make a very interesting distinction between 'causing death' and 'killing': while killing, in the medical context, is commonly associated with a wrongful act that faces against the fundamental principle that 'doctors must not kill', in other contexts (like war or self-defense), killing can be justified. The argument is a good reminder that in bioethics, it is always necessary to accurately evaluate some distinctions. In the case of the withdrawal of LST (such as artificial

✉ Susanna Maria Taraschi
Susanna.Taraschi@unicatt.it

[1] Catholic University, Milan, Italy

nutrition and hydration), suspending LST is an act that, for sure, causes the death of the patient and, from the ethical point of view, is a condemnable and punishable act. But on the other side, the withdrawing of treatments that procure more harms than advantages is ethically required.

The chapter is rich in examples, cases, and argumentations, and everything is presented in a very simple, clear, and understandable way. The authors, in fact, explain that 'in arguing that withdrawing LST causes a patient's death, we do not adopt any particular philosophical or scientific theory of causation: rather, we appeal to our common-sense understanding of the causes of particular events' (p. 6). Common-sense here is intended not necessarily as corresponding to what most people judge to be correct or right, but a 'critical' common-sense. A critical approach is quite fundamental in bioethical argumentation because it allows one to weigh up the pros and cons of various theses in an objective way.

An interesting paragraph is dedicated to the notion of 'omission': the authors discuss what cases and acts can be considered an omission, and consider as morally justifiable acts based on self-determination. This is a very delicate point, from the ethical perspective, because it opens and involves a wide discussion about the limits of personal choice. For sure, according to the authors, 'we are morally responsible for voluntary acts that can be attributed to us, whether right or wrong. Specifically, a clinician is morally responsible for causing a patient's death by withdrawing a ventilator when this life-terminating act can be attributed from a moral perspective to the clinician' (p. 18) and the withdrawing of LST causes the death of the patient.

In chapter 2, the authors analyze the practice of physician-assisted suicide (PAS) in which the clinician provides the patient with the means to cause death and finally induces death by injecting lethal medication. They examine different theses and discuss them systematically throughout the whole chapter, and then they conclude that 'patients have no right to receive lethal treatment on demand and physicians have discretion as to whether to honor these requests' (p. 51). The authors also underline how thinking that the withdrawal of life support causes the death of patients undermines the traditional lines of medical ethics, which consider those practices legitimate palliative care while, at the same time, consider active euthanasia (caused, for example, by a lethal injection) to be *presumably* illegal. This is another very delicate point: in fact, morally and politically speaking, no one has the right to stop someone else's life. This is a key concept that I would recommend readers keep in mind while reading the chapter. A careful reader must always distinguish the various argumentative levels so as to evaluate appropriately.

According to the authors, medicine's professional integrity does not exclude active euthanasia but limits the practice to a last resort intervention as a means to alleviate the suffering of incurable patients. The thesis is certainly very strong and should be carefully evaluated considering that the act to suspend treatments that can cause the patient's death is different from palliative care. But above all, the suspension of treatments that can cause more harms than benefits to the patient is different from the suspension of real vital supports.

Chapters 3 and 4 are devoted to the issue of the determination of death in terms of neurological criteria or circulatory–respiratory criteria. The authors defend the latter against the thesis of some philosophers and bioethicists according to whom there is

a 'higher brain' standard of death that considers a person to be dead when the person has lost the capacity for consciousness. Specifically, in chapter 3, the authors develop the issue of how the determination of death has changed through the ages, including after the advent of the mechanical ventilation. They examine in depth different diagnostic requirements for determining brain death, lingering on the question, 'Are brain-dead patients really dead?' (p. 59). They propose different ways to consider brain death (as a destroyed brain, as the prognosis of cardiac arrest, as the loss of integration), and they conclude with the analysis of the circulatory–respiratory criteria versus the neurological one for determining death. The authors' final thesis is that '"brain dead" individuals are not dead, though this fact is relative to a biological conception of death' (p. 79) because a human being dies when the whole organism ceases to live. But, at this point, I want to reaffirm and underline that an accurate evaluation is necessary in each single clinical case because brain death (different from *cortical* death) can determine the death of a human being in a particular phase of his development. Brain death can be considered a *criterion* to establish the death of a human being *in a particular phase of his development* (avoiding, for example, the fetal stage, etc.), but not a definition, because if cerebral death defines the death of the human being, the brain risks being considered the element that identifies the human being. Considering cerebral death as a criterion avoids the risk of falling into the erroneous anthropological perspective that identifies the human being with his brain.

In order to clarify every single thesis, it is very important to guide the reader in the topics of this book. Chapter 4 is a very good help in this regard, and it is an instrument by which a reader might practice her argumentative capabilities because it is well-structured from the schematic point of view. The chapter deals with the challenges of a circulatory–respiratory criterion for determining death and with what the authors call 'higher brain standard of death'. According to the authors, the 'proponents of the higher brain standard argue that individuals diagnosed as "brain dead" are dead because they have permanently and irreversibly lost the capacity for consciousness, which puts an end to their lives as *human* beings' (p. 87). But, set in these terms, the question is quite misleading because it seems to consider 'brain death' only in terms of 'loss of consciousness' and not in terms of 'death of the whole brain'. As the potential reader might see, the topic is very debatable. For this reason, I prefer only to highlight some core insights for reflection and leave a more complete evaluation of the different theses to the reader.

Chapter 5 is central and crucial because it deals with organ donation after circulatory determination of death (DCDD), which is the second 'pathway' for vital organ donation (the other one is donation after 'brain death', discussed in the previous chapter). In the DCDD, organs are removed after a patient has both stopped breathing and pulsing after 2–5 min, depending on the protocol (p. 97). Donors must be declared dead, on the basis of the circulatory–respiratory criteria, before the donation of vital organs (while brain-dead donors are declared dead on the basis of neurological criteria). So, in this chapter, a particular criterion for determining death is analysed: based on the thesis that the cessation of circulatory functioning must be irreversible, the determination of death is established only a very short time after the donor's heart has stopped beating. According to the

authors, this criterion has no credibility, and referring to the diagnostic criteria for 'brain death', they argue that patients are not dead in accordance with the conception of death in terms of the cessation of the functioning of an organism as a whole. One of the aims of the chapter is to present arguments showing that DCDD donors are not dead, or not known to be dead, at the time that vital organs are removed 'because the cessation of circulation is not necessarily irreversible within a very short interval after the absence of breathing and heart beat have been observed' (pp. 99, 100).

The debate around DCDD is well analysed, discussed, and put in relationship with medical practices and, in a brief paragraph, with *autoresuscitation* (p. 102). The issue arises because a key question in the DCDD debate is whether an interval of 2–5 min is sufficient to know if the loss of the circulatory and respiratory functions is irreversible. For sure, according to the authors, 'the absence of harm plus appropriate consent legitimates vital organ donation' (p. 112). But insofar as no one has ever strongly asserted that it is impossible to resuscitate patients after they have been pulseless for 5 min, this debate is still open.

In chapters 6 and 7, the authors try to investigate the ethics of vital organ donation from still-living donors in particular cases, for example, on valid plans to withdraw life-sustaining treatments without harm to the donors. In particular, in chapter 6, the authors face the question of vital organ donation without the dead donor rule (DDR), namely, the determination that donors are dead prior to organ procurement. They do so by presenting objections and answers with the aim of clarifying again some delicate clinical differences (i.e., the differences between withdrawing treatments and lethal organ procurement) and logical principles.

The authors observe that current practices of vital organ donation violate the DDR. For this reason, they propose, in chapter 7, their final chapter, a practical alternative to the status quo of organ transplantation that relies on 'legal fictions'. The authors argue that current practices relating to vital organ donation 'are based on a set of *unacknowledged* legal fictions' (p. 153). By rendering the legal fictions transparent, the authors seek to permit a greater recognition of the fact that 'vital organs are being procured from donors who are not dead or not known to be dead without overturning established legal norms' (p. 153). In order to explain this theoretical proposal, the authors start to define the concept of 'fictions': fictions are untruths that are treated as true and used to reach some aims or to maintain a 'social face', or to raise up the worries of people. A 'legal fiction' is a special category of fiction: 'A legal fiction is essentially a metaphorical or heuristic device that involves making a clearly false statement or claim in order to serve some legal purpose' (p. 154). Quoting a study of Lon Fuller (1967), they explain that 'a legal fiction can be "either (1) a statement propounded with a complete or partial consciousness of its falsity, or (2) a false statement recognized as having utility' (p. 154). This approach is used, in the following paragraphs, in order to try to understand if 'whole brain death' could count as a legal fiction or if DCDD involves a legal fiction. The proposed arguments are very clever, interesting, and useful for making readers aware of the complexity of the whole debate, which involves clinical, ethical, anthropological, bioethical, and legal issues.

The authors' ending thesis is that 'it is ethically legitimate for doctors to intervene in ways that cause the death of patients: by withdrawing life support for the sake of avoiding harm to them and respecting their preferences, and by procuring vital organs from still-living donors to save the lives of others under specified conditions' (p. 173). But doing this, they argue, 'requires abandoning the absolute norm that doctors must not kill and its corollary, the dead donor rule' (p. 174). Differently, as I have observed, while it is ethically required that treatments that cause more harms than benefits be withdrawn, it is not ethically acceptable to suspend basic practices like 'artificial' nutrition and hydration that are not merely medical but vital for a human being (unless, in particular cases, they could represent a harm in a specific clinical status). On the other hand, the respect of the 'preference' of the patient is an anthropological and legal question: it mainly depends on the laws of the belonging country. But it is also a very delicate anthropological and existential point that opens the debate of the so called 'living will'.

In conclusion, the authors provide a complete framework. The framework is sometimes too dense and may be quite difficult for readers seeking a clear ethical perspective. But it is surely useful for inviting and pushing readers to their own critical and accurate reflections, which, when linked to medical and ethical knowledge, is the fundamental ground on which every kind of evaluation should start.