configure reasons to respond to my colleague's worries about Mr A? Dr B's responses to questions like these might suggest to Dr Rad that Dr B is significantly motivated to have her perform a CTA because he is unfamiliar with D-dimer. Such a thread of conversation might give Dr Rad an opportunity to recognise this and try to familiarise Dr B with the appropriate scope of use of D-dimer and CTA as diagnostic tests. As a result of having pursued these questions and having exchanged responses, Dr B might become more comfortable with both these diagnostic tools as she cares for future patients in similar situations.

I have tried to show that if Dr B and Dr Rad can articulate responses to the questions I have listed, they can begin to understand what the other doctor sees at stake in Mr A's situation. Together, and in their responses, they exchange reasons, open avenues for subsequent questioning and clarification, and create opportunities for each to propose modifications to plans for what should be done for a patient. The practice of reason exchange cultivates a narrative that adumbrates possible consequences and enables the canvassing and consideration of possible justifications for doing something not doing something, or doing something in different ways. When reasons and the patterns of perception that illuminate those reasons are rendered explicit through conversation and questioning, they can be identified, evaluated, problematised and challenged. Then, communication between colleagues—consulting and consultant doctors—can become clearer, more open and more collegial.

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CORRECTION

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Several errors occurred in the paper titled, Trasplants save lives, defending the double veto does not: a reply to Wilkinson (*J Med Ethics* 2007;**33**:219–20). A corrected pdf is available as a supplementary file to this correction, available at http://jme.bmj.com/supplemental. The journal apologises for these errors.

LAW, ETHICS AND MEDICINE

Transplants save lives, defending the double veto does not: a reply to Wilkinson

Antonia J Cronin

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Wilkinson's discussion of the individual and family consent to organ and tissue donation is to be welcomed because it draws attention to the ''incoherent hybrid'' of the current position.[1] I wish to highlight some areas of his discussion and propose that, in a situation of posthumous organ and tissue donation, the cadaver has no individual rights and family rights should under no circumstances automatically outweigh the potential transplant recipients' right to a life-saving treatment.

Transplant immunobiology and clinical transplantation is a revolutionary area of medicine and has saved thousands of lives. In the UK, between 1 April 2004 and 31 March 2005, organs from 752 people who died were used to save or dramatically improve many people's lives through 2242 transplants.[2] In the US, 23 506 transplants were performed between January and October 2005 from 12 084 donors.[3] Information from available databases shows that demand for organs, cells and tissues has outstripped the supply. As of 18 January 2006, 6553 people are still waiting for transplants in the UK and there are 90 636 waiting list transplant candidates in the US.[2 3] As of 01 January 2006, there are 15 977 people active on the Eurotransplant waiting list.[4] It is likely that non-compulsory posthumous donation of organs has resulted in the loss of many thousands, possibly many hundreds of thousands, of lives and continues to do so. This is an unacceptable waste of human life.

Wilkinson's paper specifically points out that it ''ignores the background scarcity of organs and tissues'' and presents two arguments to produce a coherent defence of the ''double veto''. The first argument presented is ''the argument from best effects.'' It reads

> It is possible that, when all costs and benefits are taken into account, giving individuals and families each a veto over donation would lead to the greatest net benefit. The various costs and benefits would include the effects on supply of organs and tissues on those who receive them…

This argument clearly does not ''ignore'' the background scarcity of organs. On the contrary, it highlights the very issue. I am not clear what Wilkinson's evidence for supposing this method would lead to the ''greatest net benefit'' is exactly. This argument also seems to ignore a situation in which there is disagreement between an individual and his/her family. It seems more likely that the reverse will be true because we have operated with this double veto de facto in the UK for years and in many other places, and look what has happened. Any refusal to donate posthumously, whether by the individual or the family, costs lives. It is not a defence to suppose that doctors, whose primary duty is to care and do no harm would actively provide ''less thorough treatment'' to organ donors. This is frankly an insult to professional skill and integrity.

The second argument highlights four points about rights in the context of the paper. Firstly, that they are moral claims of decisive or near-decisive force. Secondly, they are moral rights rather than legal rights. Thirdly, rights have correlative duties. Fourthly, we can distinguish between negative rights against interference and positive rights to assistance. The second argument claims that the double veto can be coherently defended if the deceased has only negative rights of veto.

As Wittgenstein said: ''death is not an event in life'' we do not live to survive death and a dead individual is not a person at all.[5] As such it is nonsense to suppose or ''assume'' that the dead have significant posthumous interests or that they have any persisting ''negative'' or ''positive'' rights. If I die I am no longer autonomous because ''I'' no longer exist.[6] This argument is particularly strong when considered against the positive rights of the individuals on the transplant waiting list who will die for want of an organ. I agree that ''it seems unlikely that the family has any relevant negative or positive right.'' It is worthwhile pointing out here that it is more than likely that those individuals on the transplant waiting list also have families who no doubt have a considerable degree of ongoing distress. I am not disputing that the loss of a family member is not a distressing time, my argument is simply that it seems wholly unreasonable to suppose that the distress of the family members of the individual who has just died is more important than, and should automatically outweigh, the distress of the family members of the individual who is on the transplant waiting list.[6] In fact, it is possible that if organ donation were mandatory, then no such distressing conversation regarding organ donation at a vulnerable time would necessarily need to take place. Of course, making organ donation mandatory cannot eliminate the distress of a loved one's death. Many could feel their autonomy would be violated if their wishes about the disposal of their body after death are not followed. They may even feel distressed (while alive) if they know mandatory organ donation will happen after they die. However it seems wholly unreasonable that a no longer existing, and therefore no longer

Correspondence to:
A J Cronin, Institute of Medicine Law and Bioethics, School of Law, University of Manchester, Oxford Road, Manchester M13 9PL, UK; antonia.cronin@postgrad.manchester.ac.uk

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autonomous, individual's wishes should automatically prevail over another's right to a life-saving treatment. Furthermore, it seems odd to suppose that anyone should feel distress, while alive, at the thought that through their (inevitable) death they could save the lives of several others. In most circumstances, we (society) tend to give the utmost praise to those individuals who save the lives of others.

Finally, Wilkinson's conclusion that the double veto gives both family and individuals the power to withhold and override the others desire to donate is also inconsistent. Ultimately, the family, and not the individuals', decision prevails. The policy which Dr Wilkinson is trying to defend can be established by giving a veto power only to the family and there seems to be little (if any) need to try to give an individual a power to veto.

CONCLUSION

The current position with regard to organ donation is entirely unsatisfactory. Thousands of people die year after year on transplant waiting lists.[7] The ''double veto'' cannot be defended coherently in the way it is presented. We need radical solutions, not pathetic apologies, for something that either is de facto the status quo or is even more conservative than the status quo, which has cost thousands of lives.

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