
Allowing an unknown therapy can pose a risk for the re-

medical.2,3 In the described case, the patient died the mo-

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in case of family opposition. However, by allowing the family to select the optimal timing according to Eastern mystical charts, the team supports the opinion that brain death is not equal to death. This is not in line with modern consensus in Western medicine.2,3 In the described case, the patient died the moment that brain death determination was completed. What should be done if the most optimal timing according to the charts is 1 or 2 weeks after brain death determination? Would the dead patient be maintained so long on the ventilator?

More troubling from the ethical principle of justice would be keeping a dead patient on a ventilator in an ICU for almost 3 days on request of a family if no free bed were available in the ICU and another patient in need of ICU resources were in the emergency department. Would the team keep the dead patient on the ventilator and thereby put another patient at risk? In terms of distributive justice, this seems ethically unacceptable.

Finally, there is the issue of postmortem organ dona-

for organs for transplantation. They were expected to engage in activities that they would have been correct to judge as clinically inappropriate and disrespectful management of a cadaver, potentially caus-

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In Reply: Dr Kompanje defends a reasonable view but confuses the decisions made in the case with the argument presented in the Grand Rounds and the article, which offers a strong critique of those decisions. The discussion in the article argues that physicians and ethicists erred in keeping a young woman declared dead on a ventilator and erred in administering a Chinese remedy to a dead body. Kompanje
is correct, however, to raise the question of organ donation. In the actual case, the family did consider but in the end declined to donate—a point that was not raised in the Grand Rounds.

Dr McCollough does not disagree with the article’s conclusion or grounds: that the medical treatment of a dead body is a farce that violates professional integrity, hinders the acceptance of brain death, and is an unreasonable expenditure of public resources and professional effort. Rather, he objects that our discussion is not needed because the ethics of this case are straightforward. In contrast, the Grand Rounds discussant (Dr Applbaum) wondered why so many thoughtful, smart, and conscientious physicians and ethicists—not one of whom questioned that brain death is death—thought it a hard case and why others thought it a straightforward case in the other direction. Hence, we saw the need for an analysis McCullough finds unnecessary.

“Patient” in the article usually is a definite description referring to the young woman, not to her normative status, role, or relation, and “life support” is a noun, not a successive verb. So disconnecting a dead patient from life support is no more contradictory than unzipping a dead sailor from a life vest. The philosophical issue is not one of definitions. The case presents an open normative question: are physicians ever permitted or required to treat those declared dead on neurological criteria? Calling the entity at issue a cadaver (we ourselves call it on occasion a corpse) does not settle the matter.

Finally, we rejected the view that decency requires treating the father’s false beliefs in the medical benefits of a Chinese remedy for his dead child as true. Indeed, our central claim is that individuals are not entitled to have others act as if they are alive when by public criteria they are dead. Rather, we allow that, under integrity-preserving and non-burdensome circumstances, it is decent for physicians to accommodate some false medical beliefs of living patients, and physicians are permitted to accommodate the religious beliefs of dead patients when doing so would not be construed as endorsing false medical beliefs or denying public criteria of death. It would indeed be disrespectful to insincerely express endorsement of another’s false beliefs. But the article asks about action, not expression. Respect for autonomy often requires that we not thwart, and sometimes even requires that we assist, the mistaken plans of others.

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RESEARCH LETTER

Driving Fatalities on US Presidential Election Days

To the Editor: The results of US presidential elections have large effects on public health by their influence on health policy, the economy, and diverse political decisions. We are unaware of studies testing whether the US presidential electoral process itself has a direct effect on public health. We hypothesized that mobilizing approximately 50% to 55% of the population, along with US reliance on motor vehicle travel, might result in an increased number of fatal motor vehicle crashes during US presidential elections.

Methods. We analyzed national data from the Fatality Analysis Reporting System of fatal crashes in the United States from 1975 to 2006. 2 We included all presidential elections since database inception (from Jimmy Carter in 1976 through George W. Bush in 2004) during the hours of polling (defined as 8:00 AM to 7:59 PM local time). For each election, we also identified the same hours on the Tuesdays immediately before and immediately after as control days for the number of individuals in fatal crashes at the time, as described previously. 3 Confidence intervals (CIs) for comparing death counts on election days and control days were calculated by binomial tests using StatView 5.0 (SAS Institute, Cary, North Carolina).

Results. A total of 3417 individuals were involved in fatal crashes during the hours of polling on the 8 election Tuesdays and 16 comparison Tuesdays. The modal person was a young adult driving in a southern state (demographic characteristics generally stable over time). The 8 election days accounted for 1265 individuals, equivalent to 158 per day or 13 per hour. The 16 control days accounted for 2152 individuals, equivalent to 134 per day or 11 per hour. This yielded a relative risk of 1.18 on election days (95% CI, 1.10-1.26; P < .001), equivalent to an absolute increase of 189 individuals over the study interval (95% CI, 104-280).

The net increase in risk was about 24 individuals per election and was fairly stable across decades of time (FIGURE). The increase in relative risk extended to pedestrians and persisted across different ages, sexes, locations, polling hours, and whether a Democrat or Republican was elected. No difference in risk was observed in separate sensitivity analyses of individuals involved in fatal crashes during the same hours comparing the Monday before the election with control Mondays (relative risk, 0.97; 95% CI, 0.89-1.06) or comparing the Wednesday after the election with control Wednesdays (relative risk, 1.03; 95% CI, 0.95-1.12).

Comment. The increased risk of fatal motor vehicle crashes on presidential election days exceeds the risk on Super Bowl Sundays. 1,3 One explanation is increased traffic, but other factors might contribute. A 4% increase in average speed, for example, could yield an 18% increase in deaths even with no increase in average travel distance. 4 Additional factors might include distraction (driver inattention), rerouting (unfamiliar pathways),...