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Death without Essence? Towards a Practice-Dependent Ontology

Marc Sørensen

marc.soerensen@regionh.dk

Heart Centre, Rigshospitalet

Ezio Di Nucci

University of Copenhagen, Faculty of Health and Medical Science

Research Article

Keywords: Death, euthanasia, abortion, transplantation, ethics, pragmatism.

Posted Date: November 10th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11479374/v1

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Additional Declarations: No competing interests reported.

TITLE

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ABSTRACT

Despite legal convergence on neurological and circulatory standards in many jurisdictions, death continues to resist conceptual unification. Drawing on three recent paradigmatic political events in Denmark concerning euthanasia, abortion, and organ donation, we argue that this resistance can be attributed to the context-sensitivity of human understanding. Death may be most plausibly construed as a normative (but non-ethical) concept whose adequacy conditions depend on its practical function within an acknowledged margin of descriptive uncertainty. Each of the three domains highlights a distinct yet complementary ontological dimension—alongside the normativity of death, its irreversibility and opposition to life. Thus, while pragmatic integration can reconcile heterogeneous criteria without collapsing them into a reductive essence, the transfer of conceptual frames across the three domains may help resolve conflicts surrounding the dead donor rule, assisted suicide, and the contested boundaries of human life in utero. However, with respect to the morality of these cases, it appears that the intention behind the act of killing—rather than the act itself or indeed death as its consequence—plays the discriminatory role.

KEYWORDS

Death, euthanasia, abortion, transplantation, ethics, pragmatism.

INTRODUCTION

In Denmark, similarly to the United States,[1] death is legally defined as the complete and irreversible cessation of either cardiovascular (and respiratory) or brain function (Retsinformation 2006). Both criteria have achieved a degree of legal convergence, at least in the West; but, despite sustained academic efforts (Bernat et al. 2010), a theoretically unified and universally applicable physiological criterion of death remains elusive (Zeiler 2009). This not only reflects a theoretical gap but points to biological complexity and the fundamental context-sensitivity of human understanding. To shed light on the mutually constitutive relationship between the ontology and epistemology of death, we examine three paradigmatic

[1] According to the Uniform Determination of Death Act (UDDA) statuted by the President‘s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1981 (Aas 2024; Stanford Encyclopedia of Philosophy 2021).

political events in Denmark in recent years from the perspective of philosophical pragmatism: (i) the establishment of the parliamentary committee for a more dignified death (Ministry of the Interior and Health of Denmark 2025), (ii) the amendment to the Abortion Act (Hofverberg 2024), and (iii) the introduction of organ donation after circulatory death (DCD) (Mikkelsen et al. 2023). Each of these events mobilizes a prominent ontological dimension, and taken together, they illustrate how legal and clinical practices are responsive to, but also actively shape, different facets of what is ostensibly the same phenomenon. Even though our context is national, the ontology of death developed on the basis of these examples is meant to be geographically transferable, as each draws on a rich global discourse.[2] Readers will notice that the level of theoretical precision within these discourses culminates in the brain death debate. This is because, in medical practice, the domain of organ donation is where the conceptualization of death is most needed, and most advanced.

Nevertheless, a pragmatist approach to death in euthanasia and abortion could, so we argue, contribute to a more adequate account. While the concept of death is among the most extensively discussed topics in the philosophy of medicine, the heterogeneity of that concept across euthanasia, abortion, and organ donation may prove complementary rather than merely diverse, addressing three key ontological dimensions: the normativity of death (euthanasia), the opposition between life and death (abortion), and the irreversibility of death (organ donation). This short article demonstrates how these dimensions expose the inadequacy of strictly descriptive approaches and shows that prevailing unificatory projects struggle to accommodate the technologically driven demands of modern medical practice, thereby opening an avenue for pragmatic integration as an alternative to ontological essentialism.

Pragmatism, realism, and essentialism

Our introduction may prompt the assumption that our concept of pragmatism stands in opposition to scientific realism, as it historically did, but such a view would be both reductive and, to some extent, misleading. In the following, our sole aim will be to suggest that pragmatism provides explanatory resources in contexts where the idea of a unified, observation-independent conception of death, grounded in a single defining criterion, is no longer plausible. Although many pragmatists, especially neo-pragmatists in the tradition of Richard Rorty, regarded themselves as anti-realists, there have repeatedly been attempts to bridge the gap. For example, the founder of pragmatism, Charles Sanders Peirce, explicitly

[2] We think the paper provides an argument that can be applied universally. When we take Denmark's political situation as our point of departure, this is for two reasons. First, as citizens and public employees, it is the context with which we are most familiar. Second, it supports our pragmatic approach by providing an immediate practical point of reference.

regarded himself as a realist. Accordingly, the pragmatism advocated here is, on the one hand, fundamental since it takes practice as the epistemological starting point.[3] On the other hand, it is also theoretically "open" and therefore not incompatible with scientific realism, insofar as the latter is not essentialist or descriptivist, that is, insofar as it does not attribute necessary observation-independent or exclusive value-free core properties to its object.

THE ONTOLOGY OF DEATH

At least two overarching ontological concepts of human death—transcending the criterial level of brain and circulatory death—can be distinguished in medical practice and literature. They have most often been termed the *biological* and the *psychological*, the former being more commonly invoked in clinical contexts (Lizza, Lazaridis, and Nowak 2025). Although the biological concept can be subdivided into several competing accounts, its core assumption is that human death can be described objectively as the cessation of a natural phenomenon that long preceded the evolution of humanity and which is analogous to the death of other animal life. By contrast, the psychological concept of death, as traditionally advocated by Robert Veatch and more recently revisited by Sean Aas (2024), holds that human death differs from the death of non-human organisms in a *social* way. This difference is explained either by the claim that human death is irreducibly moral—inasmuch as it grounds our obligations towards the dead as opposed to the living (e.g., with respect to discontinuation of treatment, organ donation, and disposal)—or by the view that it depends on the loss of higher cognitive functions (Nowak 2023). Beyond the dichotomy between the biological and the psychological understanding, it has also been debated whether death should be understood as a synthetic (a posteriori, inductive) or analytic (a priori, deductive) concept, and whether it is best conceived as a state or a process (distinct from the process of dying). Furthermore, some authors question whether unification is required at all, or whether multiple conceptions of death can legitimately coexist within pluralistic legal theory.[4]

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[3] This approach is inspired by Harald Wohlrapp's pragmatic dialectics. Wohlrapp belongs to the second generation of the Erlangen School. In post-war Germany, this group developed methodological constructivism through the integration of Anglo-American and Continental influences. In Wohlrapp's case, this project culminates in an extensive theory of argumentation that connects the pragmatism of Peirce, James, Dewey, and Mead to, first and foremost, Hegelian dialectics. Unlike former epistemologists, he does not ground his theory in a concept of analytic truth but instead bases it consequently on his concept of practice (Wohlrapp 2014).

[4] See (Zeiler 2009). A similar suggestion is made by Aas (2024) and Andrew McGee and Dale Gardiner (2017) regarding DCD. Amir Halevy and Baruch Brody argue that death may be lacking a sharp boundary separating it from life (1993). However, their approach differs significantly from the one developed here. First, it provides a legal alternative to death. While this is certainly welcome, it is practical rather than pragmatic in the philosophical sense.

Much of the debate centers on the criterion of brain death. Although standards for its practical application vary across jurisdictions, the irreversible loss of total brain (at least brainstem) function is widely operationalized as the death of the human being.[5] The brain death criterion emerged alongside advances in critical care and organ transplantation, both of which required a more precise distinction: to justify the withdrawal of futile life-sustaining treatment and the timely retrieval of vital organs for transplantation (without violating the prohibition against killing the organ donor[6]) through novel ethical and legal norms. Yet despite its widespread acceptance, the brain death criterion continues to face criticism of both its internal consistency and its external discrepancy (McGee and Gardiner 2017). It has been argued that it cannot be reliably distinguished from certain other conditions of the human organism, nor is it entirely clear what, precisely, is lost through it (Stanford Encyclopedia of Philosophy 2021).[7]

Whereas some theorists defend a higher-brain standard,[8] according to which human death consists in the irreversible cessation of consciousness as the essential (i.e., necessary and sufficient) capacity for being an embodied mind or person, this standard has not been adopted in any jurisdiction. The relationship between brain structures and mental states remains insufficiently understood and does not readily extend to non-human organisms either. A more widely applicable biological account of death therefore tends to focus on the cessation of the organism as an integrated whole—conceived as a locus of interactivity or as a system maintaining anti-entropic homeostasis (Gligorov 2023). The notions of "wholeness," "integration," "interactivity," and "homeostasis"—in contrast to the mere aggregation of organic substances and processes—are thus central to this debate, and considerable effort has been devoted to clarifying their relevance to human life (Scherz 2022). That said, the psychological perspective plays an undeniable role in the pragmatics of human death. Whether it constitutes an irreducible dimension or merely a supervening feature, and how it relates to non-human organisms (or man-made information processing systems), nevertheless remains unsettled.

Euthanasia and normativity

Second, they treat the conditions discussed in their article (coma, the vegetative state, and asystole) as distinct categories, whereas we see in pragmatism a potential for unifying them.

[5] According to Mark Brown in 2019 all US states and 70 countries worldwide had adopted the determination of death by neurological criteria; see (Brown 2019).

[6] This claim is referred to as the "dead donor rule"; see (Schou et al. 2021).

[7] The concept of biological life, and within it the notion of the organism, is no less controversial than the concept of death.

[8] So does Veatch.

In recent years, support for euthanasia has increased both within the bioethics community and among the general public in many countries (Teo 2024). In Denmark, euthanasia remains legally restricted to so-called *passive* euthanasia (i.e., the omission or voluntary[9] withdrawal of life-sustaining treatment), although growing attention to the social consequences of prohibiting *active* euthanasia (i.e., the administration of a lethal substance by a professional)—fueled by public surveys and several high-profile media cases—has prompted the Danish government to appoint a committee to prepare a reflection paper as a basis for public debate. As in the international discourse, summarized in a review by Andreas Fontalis, Efthymia Prousali, and Kunal Kulkarni, the Danish debate has focused on a perceived dilemma between, on the one hand, the value of life and, on the other, patients' right to decide autonomously about it. Arguments concerning slippery slopes and social discrimination have also been raised but appear secondary to this "...crucial issue" (Fontalis, Prousali, and Kulkarni 2018, p. 409).

As views on euthanasia are not uniformly distributed in Danish society, it is reasonable to assume that the moral background is likewise interpreted differently. In our experience—as an intensivist and a bioethicist—supporters of legalizing active euthanasia (often laypersons, philosophers, and politicians) tend to emphazise the diminished subjective value of life under conditions of severe suffering, as well as individuals' (alleged) right to decide freely about its ending and to seek professional assistance—thereby bringing "the issue" into practical focus. By contrast, those (often physicians) who do not necessarily reject this argument[10] still maintain that the intentional killing of another human being constitutes a prima facie harm. The relative neglect of how intention, when translated into action, is experienced as morally injurious may help explain why the debate remains unresolved. Opponents of euthanasia often implicitly presuppose one of two dominant frameworks: killing as the violation of a moral absolute or killing as a potential harm to the subject—whether conceptualized in deprivationist or other terms. Both approaches center on the patient and treat the wrongness of killing as derivative of its impact on either a deontic rule or the person whose life may be ended. However, neither adequately accounts for the moral experience of the agent who intentionally ends that life—the person who must assume responsibility and whose involvement is necessary for lawful euthanasia. For many clinicians, it is likely that it is this experience that grounds their moral hesitation, which cannot be easily reduced to concerns about autonomy, suffering, or metaphysics. Instead, there may be a concern for moral corruption through practice.

Thus, rather than talking past one another using incommensurable frameworks, participants in this debate

[9] Non-voluntary, if the patient is not asked or is unable to respond.

[10] Although some do. See, for example, (Härtling 2021). The pro argument is held by Thomas Søbirk Petersen and Morten Dige, among others; see (Petersen and Dige 2022).

could begin by acknowledging the seriousness of all open objections and focus on the reasons for the decades-long persistence of disagreement. Ethical argumentation should explicitly address the broader implications of implementing one's own proposition and offer responses both to its potential side effects and to opposing concerns. Even if deficiencies in palliative care were remedied, as has been suggested, cases of refractory suffering would likely remain. Likewise, physicians' reluctance may reflect a form of privileged insight arising from frontline clinical experience, rather than a strategy to preserve professional decision-making authority. Legalizing physician-assisted suicide (PAS), as proposed by the committee, would mean that doctors facilitate the act while patients perform it. This could help mediate the conflict, as it acknowledges elements of both positions, especially in contexts where conscientious objection clauses are permitted. Moreover, the metaphysical "sanctity of life" objection—an argument that may appear less compelling in a pluralistic and secular society that already permits withdrawal of life-sustaining treatment and killing under certain conditions, such as war and self-defence—might be more fruitfully reframed as an expression of a reluctance to (intend to) kill.[11] Its portrayal in the debate introduces a metaphysical assumption that neither corresponds to reality nor serves the debate well. Many clinicians accept the foreseeability of death as a side effect of symptom relief but resist intending death as an end. Accordingly, the intention/foresight distinction—familiar from the doctrine of double effect—continues to play an important role in clinical practice, even if it remains philosophically contested (Di Nucci 2014).

Abortion and opposition

Death is commonly understood as the end of life and as incompatible with it,[12] which is why the properties that mark an individual's death cannot have been present from the outset. Accordingly, the end of human existence directs attention to its beginning, when these properties are not yet developed—that is, to the stage at which the zygote begins to differentiate after conception (Brown 2019). While the ovum, sperm, and embryo are all "human," the question of when an embryo or fetus should be regarded as a human *being*—and when *it* becomes a person—lies at the heart of the abortion debate. Abortion on maternal request (for women aged 15 and over) up to the 18th week of pregnancy was legalized in Denmark on 1 June 2025, replacing the 12-week limit introduced in 1973. This reform caused relatively little public controversy, did not significantly intersect with debates on euthanasia, and was approved first by a majority in the Danish Council on

[11] The assertion that the sanctity of life principle cannot be claimed to possess a universal appeal is held by, among others, Helga Kuhse and Peter Singer; see (Clarke 2023).

[12] This does not necessarily mean that "development and degeneration are [...] interchangeable", as Bruce Blackshaw and Daniel Rodger remark in a response to M. T. Brown; see (Blackshaw and Rodger 2020, p. 551).

Ethics and subsequently by Parliament. Whereas the 1973 law focused on the severe consequences of illegal abortion,[13] both legislative frameworks were motivated by the aim of extending women's right to self-determination. In doing so, they effectively place the moral status of the fetus in tension with that of the mother, subordinating the former to the latter.

More recently, legislators have faced calls to harmonize abortion regulations within the European Union, given notable differences across Western democracies—from the United States, where the federal protection of early-term abortion was overturned by the Supreme Court in 2022, to the comparatively liberal policy of Israel (Gross 2002). These differences reflect a lack of consensus on, first, up to what gestational age—if any (embryo, fetus, or even neonate)—termination of pregnancy (or neonatal life) should be permitted and, second, which features are decisive for moral status: viability ex utero, individuation from parents and siblings, or the expression of personhood. The crucial issue is how these features are defined and how they are weighted. Embryonic individuation begins at fertilization, when gametes fuse to form a genetically distinct zygote. Although monozygotic twinning may occur up to two weeks after conception, early development is not strictly deterministic, and epigenetic processes contribute to individuation. Spinal fibers reach the thalamus at approximately seven to eight weeks, and thalamic projections reach the cortical subplate at around 14–16 weeks, although their functional significance remains uncertain. Delta brain waves can be recorded between 16 and 20 weeks as an early sign of coordinated cortical activity, and these patterns continue to develop alongside psychomotor capacities during fetal life and infancy. The emergence of consciousness is unknown and may not yet occur even in extremely premature infants who today routinely receive intensive care. Such infants are named, granted legal status, and readily perceived as persons within contemporary family-centered neonatology. Consequently, decisions to withhold or withdraw life-sustaining treatment in such cases are not qualitatively different from those made for other patients. As Ingmar Persson has argued—and as is routinely observed during ultrasound imaging of fetal movement—prenatal life exists prior to 16 weeks of gestation (Persson 2002). If one accepts that the embryo in its pre-cerebral state is a living and developing human being, and that criteria for the beginning of human life therefore cannot depend on the brain alone, it follows that one should be cautious in equating human death with the loss of brain function. Even if this does not refute the validity of the brain death criterion, it exposes an asymmetry between the thresholds defining the beginning and the end of life (Blackshaw and Rodger 2020). The abortion debate thus exemplifies what we call the ontological dimension of the opposition between life and death: it raises the question of whether, and if so at what point, the life developing in utero is the kind of life whose termination constitutes a human death. Divergent legal frameworks answer this question differently because they assign varying weight to the organism, potentiality, personhood, viability,

[13] In Denmark, abortion had been legal on medical and ethical indications since 1937.

and maternal autonomy. For our purposes, this diversity highlights why a pragmatist integration—sensitive to clinical and legal contexts—may be more promising than the search for a single descriptive essence.

Organ donation and irreversibility

In 2024, Denmark introduced vital organ donation from donors who have not been (and will not be) declared brain-dead, but for whom recovery is considered impossible and life-sustaining treatment would otherwise be withdrawn. If eligibility for organ donation is established (donor or proxy consent has been obtained), life support is discontinued following preparatory measures. Once vital signs have been absent for at least five minutes of stand-off, the donor is declared dead, and organ retrieval proceeds. The rationale for this increasingly widespread supplement to conventional organ donation after brain death (DBD) is the persistent shortage of transplantable organs, as the number of eligible donors who meet the clinical criteria for brain death is limited. Accordingly, DCD has been shown to increase the number of transplants—constituting roughly one third of all donations in 2025—without compromising graft quality.

The ontological shift introduced by DCD is subtle but significant. Whereas in DBD the extinction of consciousness and brainstem reflexes (or cerebral perfusion) is regarded as irreversible, in DCD death is declared according to the concept of permanence developed by James Bernat. This concept holds that death may be declared in the permanent absence of vital signs, even if strict irreversibility has not yet been achieved. In the interim, restoration of brain function is possible in principle, but would require the reintroduction of previously withdrawn life-sustaining measures. By the same token, graft preconditioning in DCD is achieved through normothermic regional perfusion (NRP).[14] Occlusion of the carotid and subclavian arteries or the descending aorta prevents cerebral reperfusion (and thus the potential restoration of brain function) while circulation to the thoracoabdominal organs is re-established. In other words, permanence (and thereby the irreversibility) of death in DCD is contingent upon physicians' decision not to re-intervene. Death thus ceases to be a purely descriptive term and becomes, at least in part, the outcome of the application of pragmatic and predictive norms (Schou et al. 2021).

DISCUSSION

The above examples of recent national initiatives in Denmark illustrate, first, how death is conceptualized differently across clinical settings and, second, how these conceptualizations change over time in response to evolving technical and

[14] A variant of extracorporeal circulation, formerly named extracorporeal interval support for organ retrieval (EISOR).

social circumstances.[15] Following Wittgenstein's cluster theory, Winston Chiong suggests that death, like other biological entities, may exhibit a family resemblance structure, thereby introducing a degree of inherent indeterminacy (Chiong 2005). As in the case of legal adulthood, where for practical reasons we define a cut-off point within a borderline region between distinct poles, so too the distinction between life and death may be better understood as a continuum rather than a dichotomy, with each individual feature characterized not by an underlying essence but by varying probabilities of occurrence along different trajectories.[16] Death could be an operational point of maximized semantic coherence of these features, reflecting the purposes its definition is meant to serve.

Practice, we may assume, has historically shaped concepts of death, just as those concepts have, in turn, influenced practice. The introduction of artificial ventilation, along with the development of extracorporeal circulation and membrane oxygenation, has had a profound impact and challenged our understanding of human death by the needs of organ donation and, last but not least, the possibilities of prenatal diagnosis, abortion and life-support of extremely preterm infants, both complicating it and—precisely for that reason—prompting its articulation. This can be explained by the fact that human observation and understanding are constitutively directed towards forming adequate representations of the agent's environment. In a pragmatist sense, adequacy does not imply correspondence, but rather a cognitive construction that enables successful practice. According to pragmatism, death is a construct that is conditioned by this teleological orientation. Its content is fixed within a purposive framework that enables actions which would otherwise be impermissible or futile: to protect ourselves from the threat death poses, we must understand it in a way that allows us to influence, i.e., prevent or at least postpone it—and to know how best to mourn the deceased. However, objectifying death through research does not entail that we thereby describe death as it is in itself; rather, the subjective perspective is transcended and replaced by a transsubjective one—presumably more adequate, yet still actively engaged. This applies equally to all concepts of death including the biological, which is not merely the objective counterpart of a subjective psychological account but, like the latter, depends on practice.

With this in mind, we should ask not only whether ontological unification is possible but also why, and to what extent, it may be necessary (Zeiler 2009). Within a pragmatist framework, integrating different concepts may enrich theoretical understanding and feed back into the various discourses and their shortcomings, even if full unification

[15] Over the past forty years, Denmark has moved from relatively late recognition of brain death in DBD to relatively early recognition of permanent cardiovascular death in DCD. A controversy worth reading was published 1990 surrounding a statement from the Danish Council on Ethics criticizing the abandonment of the criterion of cardiac death (Rix 1990).

[16] See also (Halevy and Brody 1993).

is neither attainable nor required. On this view, concepts of death need only be unified insofar as doing so exhausts their integrative potential in relation to the kinds of cases discussed. It seems reasonable to expect any contemporary theory of death to address at least the three ontological dimensions identified above: the normativity of death (as opposed to the sanctity of life), the opposition between life and death (rather than their strict contradiction), and death's irreversibility (or permanence). These dimensions are not logically entailed, nor are they structurally uniform; rather, they may shift in response to changing clinical demands. Irreversibility, for example, is commonly understood as a state that *cannot* be reversed and is therefore in tension with the concept of permanence in DCD, according to which a state *will not* change because life-sustaining measures will not be reinstated (McGee and Gardiner 2017). Various attempts have been made to resolve this tension. McGee and Gardiner for instance argue that irreversibility has always been hypothetical, since we can rarely—perhaps only after cremation—exclude the possibility that death might be reversed under future conditions or at the cellular level.[17] On this view, death is a synthetic concept—a claim sometimes invoked in light of reported cases of "brain death" survival.

At the same time, it seems difficult to maintain that death is a purely descriptive term, especially in the absence of a consistent definition and in light of implausible implications arising from certain cybernetic models (Brown 2019; Blackshaw and Rodger 2020). As Bernat suggests, it is important to distinguish between the *definition* of death and its *criteria* and *tests* (Boniolo 2007). Whereas tests provide only descriptions, definitions and criteria involve determinations. The apparent dichotomy between the biological and psychological conception of death may thus reflect different epistemic acts or functions. John Lizza, Christos Lazaridis, and Piotr Nowak make a compelling case for aligning these distinctions with established clinical practices (Lizza, Lazaridis, and Nowak 2025), which rely on a reductionist account. What receives insufficient attention, though, is that, insofar as practices are shaped by underlying interests, the movement between definitions of death, its criteria, and tests is bidirectional (Gligorov 2023). The principle of permanence, as well as brain death diagnostics, is primarily relevant within the specific context of vital organ donation. In this domain, some appear to prioritize adherence to the dead donor rule—thereby excluding the act of killing—over the determination of an unambiguous descriptive state *sui generis* (Nielsen Busch and Mjaaland 2023*)*. Others prioritize conceptual clarity and therefore advocate abandoning the rule, thereby directly confronting professional reluctance to kill (Nair-Collins 2024). While life-sustaining measures are typically initiated by physicians and later withdrawn in cases of

[17] A similar argument is provided by David Hershenov; see (2003) and Scott Halpern and Robert Truog; see (2010). It has been estimated that several hundred people worldwide are currently cryopreserved in the hope for a future possibility of cure and revival.

futility, the removal of a vital organ from a living donor could be interpreted as intentional killing, akin to active euthanasia (Masek 2025). In such cases, we may condone death following withdrawal without thereby condoning killing, treating death as normative yet morally neutral (analogous to certain conceptions of disease), whereas killing remains ethically charged. As suggested in the euthanasia section, killing, on the other hand, may be considered justifiable if it is unavoidable in realizing a higher-order good and is more consistent with the view that, although human life is highly valuable, it may not be inviolable. The appeal of PAS may lie precisely in allowing the acting subject to draw this distinction, which may best balance the intention towards the act with the aversion to it, as the agent and actor would be one and the same person.

Similarly, in weighing maternal and fetal interests prior to abortion, the future well-being of the potential child is taken into account. Although public debates on abortion and euthanasia in Denmark have not directly influenced one another, underlying tensions are evident. Obstetricians generally regard medically induced termination of pregnancy as standard practice. At the same time, clinical care may include a psychological focus on personalizing the fetus to facilitate processes of grieving and healing. Anthropological studies document mothers' experiences of responsibility for the act of termination and clinicians' awareness of the moral burden involved in surgery (Heinsen 2022; 2023). In each case, the argumentative involvement of patients and their families as participants in a constitutive discourse is crucial. While some conceptual flexibility may be warranted, this flexibility must be transparent and justified through reasoned argument with them, particularly given their differing perspectives and their role in experts' acceptance of the cognitive representations in question (Sørensen and Andersen 2019). A deliberated proposition attains constituency if freedom from objections has been achieved or can reasonably be expected (Wohlrapp 2014). Consent, in turn, may be questionable if the underlying theoretical assumptions about death are not adequately understood by all parties (Aas 2024). In particular, we should avoid presenting a psychological concept of death as if it were purely biological. With respect to abortion, the decisive factor may not ultimately be the attribution of humanity to the fetus *per se*, but rather the fetus' dependence on the mother and her acceptance of it—as would be a patient's acceptance of life in dependence on artificial support. In this way, descriptive features and norm-based considerations (though not ethical judgments as such, in contrast to killing) are intertwined in death as a practical matter. This also explains why the potential benefits of organ transplantation, abortion, and euthanasia—measured in terms of quality of life gained or suffering avoided—inevitably and justifiably influence our nosological thinking.

CONCLUSION

The concept of death plays a central role in medicine and healthcare, as it guides clinical practice at the end of life. Yet despite extensive debate in academic circles, it remains uncertain whether the concept can be unified and what ontological status it would have if it were. Here we have drawn on three recent political developments in Denmark to suggest minimum requirements for such a concept and to explore the extent to which a pragmatically integrated framework may help resolve conflicts across the respective practice domains: euthanasia, abortion, and organ donation.

Within a pragmatic framework, the scope and adequacy of a definition are determined by its function in practice. Accordingly, a pragmatic definition of death would be appropriate if it successfully fulfils its intended aims—namely, to enable the termination of unwanted pregnancies, ending the lives of unrelievable suffering, and the retrieval of organs for transplantation—without generating formal objections. The difficulty, however, is that a degree of inductive uncertainty remains inherent to this aim, as full empirical control is typically unattainable. At the same time, cases such as living fetuses in a pre-cerebral state, thriving anencephalic neonates, and reported instances of brain death survival call into question the robustness of even the most advanced criteria for determining death. These considerations suggest, as others have argued, that the concept of death is best understood as a broader normative—though not ethical—construct, marked by descriptive uncertainty, rather than as a strictly descriptivist depiction. Theoretical coherence might be improved if death, in its narrower role as a prerequisite for organ donation, were replaced by the process of dying. The resulting ethical problem of killing, in turn, could benefit from insights gained in the contexts of euthanasia and abortion. As regards the moral evaluation of such practices, it appears that it might be the intention behind the act—rather than the act itself or the resulting state of death—that could play the discriminatory role.

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