Ethical Issues in Organ Donation after Circulatory Declaration of Death

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Ethical Issues In DCDD

Are patients who are typical donors deceased?

New protocols to improve procurement—challenge to Dead Donor Rule?

Ethical tensions in management of living patients who are donors

Futility cases: donation when the family does not consent to withdrawal

Research Ethics issues around innovations and who should consent

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The Dead Donor Rule

Prohibition against removal of organs necessary for the life of the patient

Alternatively, prohibition on intentionally ending the life of a patient through organ removal

DDR defended

DDR is a special case of active euthanasia (killing by organ procurement)

Therefore, it is currently unlawful in all 50 states as a violation of homicide laws

Current legal landscape in the U.S.—PAD spreading, but laws reflect deep ambivalence towards practice

No evidence of major legal and social shift necessary to legalize AE and hence abandonment of DDR

Defining Death

- UDDA--- “An individual who has sustained irreversible cessation of circulatory and respiratory functions…is dead”
- What does “irreversible” mean
  - Will not be reversed (because no attempt to reverse)
  - Can not be reversed (even if attempted)
- Sometimes characterized as difference between “permanent” vs “irreversible”
- But---how long before “cannot be reversed” threshold met? Too long

Defense of DCDD and DDR

- At the time of the writing of the UDDA, the commissioners used the terms “permanent” and “irreversible” interchangeably
- In non-donation contexts, “permanent” is the standard, not “irreversible”
  - If patient is full code, declaration not until after attempts have failed
  - If no code, patient is declared shortly after cessation
- Idea of a metaphysical line that divides life from death the point when resuscitation is impossible is implausible (as technology changes so does that line)
- Permanent cessation is what matters and is a plausible interpretation of “Irreversible” (though UDDA revision could clarify)

ECMO protocol to improve donor management

Immediately after death declared, ECMO provided (pre-op placement required)

Intra-aortic occlusion balloon blocks blood flow above diaphragm

Allows potential for procuring hearts

Are these patients dead?

How can we say cessation is irreversible if we plan to reverse it?

Remains controversial as a protocol

Blood circulation to the brain is not restored---is that sufficient to accept a declaration of death? Could progress to death by neurological criteria

If other alternatives to better management and improvement of organ retrieval are developed, may be ethically preferable

Ethical Tension in Management of DCDD

- Core ethical requirement---decision to withdraw life support on a living patient should not be made for the purpose of organ procurement
- Implication: discussion and consideration of organ procurement must be preceded by family decision to withdraw life sustaining treatment

Tension #1---Timing

- Unlike brain death (where teams know when they will do exams), the timing of when families will decide to discontinue life support is variable and often uncontrolled—therefore, OPO staff may not be on site when decision is made
- Family will often want to discontinue life support as soon as they have made that decision
- Challenge for having discussion about procurement with family
- Greater challenge for FPA, where family wants to withdraw but delays may be required

Tension #2---Conflicting Interests

- Conflicts between other interests and values of the patient and interests and value of patient in donation
- Patient's family may express that patient never wanted to be resuscitated, but that may be necessary to keep donor alive for procurement to proceed
- Families sometimes reluctant to accept poor prognosis and insist on all life support for a long time (even if not in accord with patient's values). After great effort to get family to accept, if they reject donation for FPA, they may respond by rejecting shift to comfort care

Tension #3--Communication

- Often with families who are reluctant to accept prognosis and attempt to delay moving forward, teams push for discontinuation quickly. Challenging when OPO wants everything to then slow down.
- Recent case---teams have been explaining for weeks that patient's kidneys are shot and will never work again, same for other organs for a patient in multi-organ system failure. Hard for family to understand why we can then procure those organs and have them work for someone else.

Unshared decision to withdraw

- Ethical starting point is that procurement takes place after family makes decision to withdraw life sustaining treatment
- But what if family never agrees to withdraw and the hospital and the teams invoke futility, or medically ineffective care, non-beneficial care, etc?
- First, will OPO be willing to still speak with family to potentially authorize procurement, when family is objecting to the withdrawal and they have failed in efforts to arrange a transfer?
- In case of FPA, family may object to withdrawal and to procurement, yet both would be happening over their objection---optics of that situation could be problematic

Resolution of Tensions

- Communication and coordination as much as possible between the OPO and the teams caring for the still living patient
- Clear boundaries about what is and is not appropriate---the interests of a still living patient will always have to come first
- Some level of tension unavoidable---in spite of claims to the contrary there are occasions when the interests of donation and of the patient (and their families) are in conflict