

Euthanasia by Organ Donation

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Important Note

- This talk is being given in Canada, where Medical Assistance in Dying (MAiD), consisting of either Physician assisted suicide (PAS) or Voluntary Active Euthanasia, is now legal, and considered an ethical option in the spectrum of end-of-life care.
- PAS is legal in 5 states in the US.
- Euthanasia is not legal in any state in the US.

The “Dead Donor Rule”

corollary to “The Sanctity of Human Life”

- Organs (other than paired organs or partial organs, which can be removed from living donors without adverse effect on the live donor) are only removed from potential organ donors after their death.
- *Because all lives are intrinsically valuable, it is always wrong intentionally to kill an innocent human being.*

When are you dead?



New Jersey Legal Definition

“An individual who has sustained either (1) IRREVERSIBLE cessation of circulatory and respiratory functions, or (2) IRREVERSIBLE cessation of ALL functions of the brain including the brain stem, is dead.

A determination of death must be made in accordance with accepted medical standards.”

Death by Neurological Criteria, “Brain Death”

- Whole brain concept of death
 - “all functions of the brain, including the brainstem”
 - Easier to measure (at least initially) than “cortical death”
 - But...we don’t test for all measures of the brain
 - In fact, some functions clearly mediated by the brain are clearly still present in “brain dead” individuals:
 - Thermoregulation
 - Hormonal regulation
 - Sexual maturation
 - So, are these patients actually dead? Or “as good as dead?” Or, in the process of actively dying?
 - Or are we recovering organs from people who we have *defined* as dead, for our convenience, even if they don’t actually meet the legal definition?
- Have we created what Miller and Truog refer to as a “Moral Fiction?”

Death by Circulatory (previously Cardiopulmonary) Criteria

- Requires *irreversible* cessation of circulation and respiratory function.
 - How to determine irreversible? Must attempt and fail.
 - Patients with DNR who go into PEA or become asystolic have developed irreversible cessation only because *we have chosen not to resuscitate them*.
 - In DCDD setting, how long should one wait to be sure it's irreversible?
 - Long enough to r/o "autoresuscitation"?
 - Long enough so patient could not be resuscitated?
 - Long enough so patient's brain has died even if they were resuscitated?
 - Current waiting times are 2-5 minutes, by protocol, but have been as short as 75 seconds (Denver pediatric heart DCD protocol).
 - Other than autoresuscitation, 2-5 minutes unlikely to prevent active resuscitation, nor to lead to brain death.
- Have we created what Miller and Truog refer to as a "Moral Fiction?"

Why do we care?

- Harvard Brain Death Committee:
 - ...The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients.
 - Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.
- In the absence of the need for organs for transplantation, this largely becomes a bed management issue!

How to solve this problem?

- Do away with the Dead Donor Rule.
- Can we do that?
- Previous discussion has shown that, for all intents and purposes, we maintain the fiction, but already have abandoned it.
- Why maintain the DDR?
 - Public trust...or distrust
 - “slippery slope”?
- Do we really want to wait until someone cries, “but the Emperor has no clothes!”?

But what about ‘thou shalt not kill’?

- Difference between killing and “allowing death”
 - Active vs Passive?
 - What is passive about removing an endotracheal tube? Or “terminal sedation”?
 - But that’s about relieving suffering. Goal is not to kill the patient.
 - Really? Who are we kidding?
 - Permanent unconscious or vegetative patient incapable of suffering.
 - Not really an example of Doctrine of Double Effect.
 - Goal really is to rapidly, comfortably to end patient’s life.
 - Surveys of intensivists show ending of life often the primary goal.
 - Many patients in whom we withdraw life-sustaining therapy are not actively dying, and might live years or decades with continued care.

A humble proposal

- Goal of DCD is two-fold: permit the patient to have a good death, and save lives through organ donation.
 - Patient is extubated, pressors turned off, hopefully provided appropriate sedation, management of air-hunger, etc. We maintain the fiction that extubation is to relieve suffering rather than to result in the death of the patient, though that is foreseen, and always happens, though not always in an acceptable time frame for donation.
- Rather than current DCD protocols, where we wait for patient to meet criteria for circulatory death, then rapidly recover organs, why not anesthetize the patient, remove organs, then extubate.
 - Less potential for discomfort on the part of the patient
 - Greater potential for organ recovery, fulfilling the patient's wish.

First Person Donation Makes Lawyers Squeemish Denies patient autonomy



1st Person Donation

- David Adox, 44, ALS since age 42
- Ventilator dependent
- Long-time patient of NJ hospital
- Wished to be admitted to that hospital, have ventilator removed, and become DCDD organ donor
- Evaluated by multiple physicians, OPO, not depressed, no psychiatric disease.
- Husband says this was patient's long-standing wish.
- Reviewed by hospital ethics committee, and plan approved (full disclosure – I chair that committee)
- Hospital Council and CEO denied request – “looks too much like physician-assisted suicide.
- Pt eventually able to donate liver/kidneys at a NY hospital

DCD vs Euthanasia

Current DCD protocols

- Death occurs, but unpredictably, no organs recovered in 30-50%
- Potential for discomfort during the dying process
- Not certain patient is dead at time of organ recovery
- Organs recovered limited to kidneys, sometimes liver, rarely pancreas

Euthanasia by Organ Donation

- Patient alive but anesthetized until organ recovery
- No potential for discomfort.
- Death results from irreversible cessation of cardiac function
- Organs recovered might include heart, lungs, liver, kidneys, pancreas, intestine.

Current Euthanasia vs by Organ Donation

Current Euthanasia

- Can take place at home
- Family present, if desired
- Death by pharmacologic means
- No discomfort
- Family can stay with patient after death

Euthanasia by Organ Donation

- Must take place in hospital
- Family must say goodbye's at entrance to OR
- Anesthesia induced prior to beginning procedure
- No discomfort
- Family could reunite with patient after surgery completed

Comments?

Thank you!