



Donation After Circulatory Death: When Withdrawing Life-Sustaining Treatments Is Ethically Acceptable

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ABSTRACT

The possibility to determine death based on cardiocirculatory criteria in controlled cases, namely when there is a request to withhold treatment—or, more frequently, withdraw it—specifically recalls the recent Italian law on advance treatment directives and leaves the following question unanswered: Under what conditions is the patient’s request legally and ethically acceptable?

We present three ethical proportionality criteria for supporting physicians’ decision-making facing patients’ requests of treatment withdrawal, namely: 1. irreversible pathology with an ominous and worsening prognosis; 2. within an evaluation considering both clinical data and the patient’s history; and 3. facing burdens that are no longer bearable.

We finally argue that reflection over controlled donor may be a model for giving medicine the chance to responsibly deal with broader end-of-life issues.

ORGAN transplantation is currently the gold standard for treating end-stage organ failure. However, organ shortage remains one of the major limitations to be overcome and strategies have been implemented for expanding the donor pool. These include, among others, donation after circulatory death (DCD). DCD has been classified into controlled (cDCD) and uncontrolled (uDCD) [1]. Although uDCD protocols raise fewer concerns because withdrawal of life-sustaining treatments (W-LST) is performed once treatments have proven unsuccessful, cDCD entails that physicians establish whether a treatment is no longer proportionate and subsequently proceed to W-LST [2–5]. The recent Italian law on advance treatment directives allows physicians to either withhold or withdraw treatments and reads that “The physician is bound to respect the patient’s expressed willingness to reject or give up medical treatment and, as a consequence of this, is exempt from civil and penal responsibilities. The patient may not request any medical treatment violating legal regulations, professional deontology or good clinical practices; in view of these requests, the physician holds no professional obligations” [6].

The possibility to determine death based on circulatory criteria in controlled cases [2], namely when there is a request for treatment to be withheld or, more frequently, withdrawn, specifically recalls the above law and leaves the following question unanswered: under what conditions is the patient’s request legally and ethically acceptable?

WITHDRAWAL OF TREATMENT

Given its paradigmatic character, W-LST is currently a crucial issue. By putting such action into practice, the healthcare professional is confronted with making a patient’s life shorter—no matter to what extent—by leading him/her to death. Unlike treatment rejection, which is simply acknowledged by the physician, albeit within a relational context, W-LST entails physicians to perform an action. Hence, does this make the physician responsible for the patient’s death? Or is it the patient’s pathology which is inexorably taking its own course? What is the difference between killing a person and letting a person die? Nowadays, does this distinction still make sense? All of these questions make W-LST paradigmatic with regard to end-of-life related ethical issues. Given that all of the actors involved in these decisions have a stake in the outcome, physicians and healthcare professionals may not merely claim to have performed an action they are technically able to practice to respect a patient’s will. It is actually

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more desirable, or at least less problematic, to withhold a treatment rather than withdraw it once it has been initiated. From an ethical perspective, it should be highlighted that a patient's request for W-LST is much more binding than the request not to set it off at all. The patient has gained experience of his/her condition, experienced the balance between benefits and side effects, contextualized them within his/her own existence: he/she has resisted and has finally come to the decision that the time has come to give up. To what extent is the patient's request binding? Which criteria represent the legitimate limitations of medicine and of human life by safeguarding physicians' and health professionals' responsibility to take care of suffering subjects? When is a treatment no longer proportionate [3,4]?

TREATMENT PROPORTIONALITY CRITERIA

The first proportionality criterion demands the integration of clinical aspects with the patient's personal history, namely a quality of life judgment [7]. Thus, judgment may not be separated from clinical aspects (ie, "numbers"), as it is necessary to know the chances of success of an intervention as well as the life-prolonging hope it entails. However, as these numbers have an impact on the patient's life and given his/her right to make the final decision, the size of this impact also needs to be evaluated. On the one hand, this dialectic between objective data and subjective evaluation recognizes that the subject's evaluation cannot be arbitrary (it is always related to a clinical condition). On the other hand, it indicates that the application of theoretical models that disregard the patient's actual condition is abstract and disrespectful of the human person. Legislation recognizing euthanasia also establishes specific clinical conditions for accepting the patient's request to be helped to die [8]. Thus, the separation between objective and subjective aspects is misleading and inadequate. A second criterion is the notion of time, namely the *terminality* concept, when a request for W-LST generally appears to be legally and ethically acceptable when the prognosis is less than 6 months. In the face of an irreversible pathology with an ominous prognosis, such a position is certainly reasonable, although the patient's idea of how his/her last days shall be best lived has significant relevance. Given the objective features of pathology, there would be neither abuse nor arbitrary decisions. Nevertheless, for a number of reasons, we deem it necessary to explore the ethical acceptability of W-LST when the patient is not at a terminal stage. In the first place, this clinical criterion appears to be too restrictive. Technology currently makes the long-term prolongation of life-burdening clinical conditions possible. However, both the subject and his/her family, albeit having resisted, no longer have the emotional resources—even before either physical or economic ones—to go on any further. Consider patients with amyotrophic lateral sclerosis or in a vegetative state. As the proportionality judgment—and this is the second reason—is a relationship between clinical conditions and existential patient evaluation, the terminality criterion

unjustly favors the clinical perspective. Hence, rather than terminality alone, it is necessary to refer to a patient affected by an irreversible pathology, with an ominous and worsening prognosis. A third criterion refers to the burdens that treatment places on the patient, the patient's family, and sometimes even the entire community [9]. The burdens referred to here are chiefly psychophysical ones, although economic burdens shall also be addressed within certain contexts. The core matter refers to the subjects affected by these burdens. If it is acceptable for a patient to consider a treatment to be no longer physically bearable—resistance varies from one person to another—due to its side effects (consider, for example, anti-neoplastic therapies), is it acceptable for the patient to give up because of the (primarily existential) burdens his/her treatment places on his/her family? What about the value to be attached to request for W-LST by incompetent patients' guardians—shall burdens be given as the primary reason for withdrawal itself? The burdens criterion needs to be appropriately investigated, as it plays a role in defining the proportionality of a given treatment [10]. It is also necessary to make sure if and to what extent it is possible to face these situations in order to overcome them; the underlying risk is that of endorsing a culture that neglects and excludes vulnerability as an obstacle to a life that does not admit any fatigue nor weight in order to be considered worth living. Should these criteria be present (1. irreversible pathology with an ominous and worsening prognosis; 2. within an evaluation considering both clinical data and patient's history; 3. facing burdens that are no longer bearable), the patient's request for W-LST would appear to be ethically acceptable—it would then be not an action of euthanasia but rather a renunciation of disproportionate treatments and coherent with the physician's promise to provide care [11]. In such cases, given the physician's position as a professional and as a person at the same time, the W-LST appears to be a good way of taking care of the other by respecting the patient's history.

CONCLUSIONS

The W-LST does not only deal with the removal of organs for transplantation, as it takes place regardless of the actual possibility for the patient to donate. Rather, it entails an independent evaluation that is determined on the basis of specific criteria and carried out by the physician in conjunction with the patient and his/her family. The reflection over cDCD may represent a model for giving medicine the chance to responsibly deal with broader end-of-life issues.

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