

How can you be transparent about labelling the living as dead?

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Recent developments in resuscitation --e.g. emergency preservation and resuscitation (EPR), mechanic chest-compression, and out-of-hospital extra-corporeal membrane oxygenation (ECMO)--, show that some therapeutic options are available for victims of sudden circulatory arrest on whom traditional cardiopulmonary resuscitation efforts have failed. In countries where uncontrolled Donation after Circulatory Determination of Death (uDCDD) protocols have been developed, non-conventional resuscitative techniques may co-exist with uDCDD. A number of publications have addressed this situation (Ortega-Deballon et al. 2016), including recent recommendations on the use of ECMO for therapeutic purposes or for uDCDD (Dalle Ave et al 2016).

EPR and uDCDD protocols have similar eligibility criteria and share many technical procedures, but differ in their purpose. Hospitals with expertise and resources in both protocols are faced with the choice of attempting to save the lives of seriously injured patients or, alternatively, declare them dead based on cardiopulmonary criteria so that they become potential organ donors (Prabhu et al. 2017). Prabhu, Parker and DeVita describe some of the ethical problems that arise in that co-existence, including those related to conflicts of interests and challenges to community trust, and suggest public education and institutional transparency as the proper way to deal with them. However, they overlook a further considerable challenge for transparency and trust raised by the overlap between these two protocols. The problem is that the determination of death required by uDCDD protocols (especially in same clinical setting as EPR) depends on a criterion of death that is so contingent on a variety of cultural, social and moral values as to be arguably absurd. The idea that the same patient would be regarded as dead if a decision is made to proceed to uDCDD, but alive if EPR is attempted, flies in the face of the conventional understanding of death as a biologically based, irreversible, and objectively determined state. This is problematic for a number of reasons.

First, by claiming that patients who meet eligibility criteria for both protocols necessitate “a clinical decision to pursue one or the other”, Prabhu et al. assume that there is a great deal of discretion in death determination. But on the standard understanding of the concept, diagnosis of death should be a judgment based on scientifically proven information that it would be impossible for an individual to regain his or her vital functions. In contrast, Prabhu et al. imply that whether some patients are dead or alive is a matter of choice subjected to a number of contingencies, including the neighbourhood in which they live,, ethnicity, social status, availability of resources and expertise, individuals’ preferences about end-of-life care and organ donation, and social utility. Consider the drowning sailor case:

James has fallen into the water from a boat in the middle of a storm. He is still struggling to survive among the waves in a rough sea. An officer makes a quick cost-benefit assessment of the situation and announces to the rest of the crew: “James is dead, it would be too risky for us to rescue him!”. Another officer raises his voice, “Look, we have a crane and a very skilful rescue team. James is not dead!”. Finally, a close friend of James states: “His fall was not an accident. James wanted to die, he would not like us to rescue him. He would like us to survive. He is dead”.

Regardless of how reasonable or unreasonable or ethical or unethical it would be to save the sailor, he is clearly not dead. It may be very likely or even a certainty that he *will die* soon, it may be ethical not to save him, but James is not dead *yet*. Death is not a prognosis, but a diagnosis. Contingent considerations about availability of resources or personal preferences cannot change whether or not the sailor is deceased.

Prabhu et al., however, suggest that “because of the resource intensive nature of the EPR protocol [...] it is ethical to implement a uDCDD protocol and employ it for patients who would be eligible for EPR in other settings”. By claiming this they are assuming that availability of resources determines whether a very sick patient is already dead. A counterintuitive consequence is that two individuals in exactly same clinical condition could be dead or alive other alive depending on contingent, variable and extrinsic criteria, such as geographic location, availability of resources, the need for organs and

their willingness to donate. They endorse a policy that declares dead patients who could still benefit from therapeutic interventions. The possibility of recovery is, indeed, deliberately prevented in some uncontrolled DCD protocols, where the use of “catheters to exclude oxygenated blood from reaching the brain” is intended to avoid an unwanted recovery of neurological functions.

To be clear, we are not arguing that it would be wrong to implement a uDCDD protocol in patients who have not responded to prolonged resuscitation. Like the drowning sailor, it may be ethical not to save patients in this situation. However, we should not delude ourselves that this is because of a fact about their death.

Prabhu et al. acknowledge that public scepticism and mistrust may follow from such policies, and suggest “education of the community”, “public disclosure”, and institutional “transparency” as ways of “fostering therapeutic relationships” and avoiding a backlash. In fact, if transparency is taken seriously, then uDCDD protocols should not call potential donors “dead”, and clinicians should openly ground their moral decisions of pursuing or not resuscitation on the ethical considerations of cost, available resources, and the wishes of the patient. Uncontrolled DCDD is already using of this sort of analysis, but for the purposes of death determination. As a result, the word “dead” for these potential donors appears strategically manipulated: an underlying moral judgment is disguised with a factual determination. The non-availability of resources to resuscitate dying people and their willingness to receive resuscitation are clearly ethically relevant to deciding whether or not to save them. However, they are irrelevant factors to determine their actual vital status. The world is full of patients with no access whatsoever to advanced emergency medicine. Many have do not resuscitate orders. Many have donor cards. We hardly take any of these circumstances as reasons to call them dead.

If trust is a priority and transparency is taken seriously, then uDCDD protocols should not diagnose death in potential donors. Rather, they should openly acknowledge that organ donation is permissible in patients for whom further resuscitation will be withheld, and who will as a consequence soon die. Of course, being clear about this means rejecting the so-called ‘dead donor rule’. But surveys suggest that the public may be less attached to this rule than transplant surgeons and ethicists (Nair Collins 2014). It is also,

arguably, a much greater threat to public trust to try to manipulate and contort definitions of death than to be open and honest about where and when organ donation is ethical.

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