FROM THE INSIDE

Transforming ICU death into life—radically more

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Modern intensive care saves increasingly more people and yet there is so much death in the ICU; for a lot of people (in the developed world at least) this is a common place to die these days. An estimated one in five deaths in the USA occurs in a critical care bed [1]. What if we transformed all (or many more) of those deaths into new promises for life? There are currently 121,650 people needing a lifesaving organ transplant in the USA with 22 patients per day dying on the waiting list [2]. This number likely substantially underestimates the problem since a large number of patients are arbitrarily excluded from waiting lists. Even larger numbers remain on long-term dialysis. The demand is also rising, because of the increasing burden of certain types of organ failure (e.g., due to diabetes), and widening eligibility criteria for transplants.

We ought to take seriously “radical” proposals of increasing the pool of available organs. Organ conscription from the dead [3, 4] and organ donation euthanasia (ODE) [5] have been both proposed yet are usually quickly and uncritically rejected as being too extreme, too utilitarian. At the same time we take it as standard and ethical practice to bury or burn healthy organs that could save lives and dramatically improve others. It is easy to call such proposals strictly utilitarian when we blatantly ignore the duty we have towards these waiting recipients. If their plight does not generate a duty to help then what does? Nobody is proposing to compromise our devotion to our intensive care patients; that will always be our primary duty, and the argument that these proposals will lead to negligent and/or opportunistic behavior is simply fear mongering. The fact is that many pathological

states do not have a cure, many clinical problems do not have a solution, and patients will die despite valiant efforts, excellent clinical care, and all available advanced technology.

The above points should also suggest that the dominant underlying intention of “radicals” is not the mere maximization of aggregate good. The direction is more consistent with communitarian ethics incorporating both deontological and consequentialist features: Deontological, because the motivation to consider these proposals is based on acknowledging the moral and justice-based duties we have towards recipients; consequentialist, for targeting proposals of maximal efficiency. A further note from a moral theory standpoint is that although there may initially be a flavor of act consequentialism (in the sense that more organs will become available from conscription and/or ODE), the proposals become questionable when examined by the more sophisticated version of rule consequentialism. The caveat is that if these policies lead to an adverse public reaction reducing total organ availability, the proposals would be considered immoral under a purely consequentialist (or utilitarian) framework.

Patients who meet neurological criteria for death should have their organs made automatically available followed by the burial or cremation practices that families chose to follow. Organs here are considered as a type of public good and/or public property, and vetoes to their use either from the deceased or their family are dismissed on the basis of the following assertions: (1) organs are of no use to the deceased, (2) organs from the deceased are of no use to the family (an exception here could be considered and priority given to a family member who may be on the transplant list), (3) these organs will inevitably destruct if not harvested, (4) the life-preserving claims of living autonomous persons trump ante-mortem autonomy claims.

Organ procurement and body disposal should be separated. In order to pay the necessary respect for the

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deceased and their family, appropriate clinical protocols should minimize inconveniences from procurement procedures. A standardized protocol where families are not involved during procurement, and in that way are not put under pressure or have added stressors in such a time, would ensure that all viable organs become expediently available and that the body is then returned to the family.

Organ donation euthanasia would replace the end of “end-of-life” care. Once the patient and/or their family in conjunction with the clinical team has decided that any further care would be futile and/or undesirable, for eligible candidates who have consented, a clinical protocol of assuring comfort and ensuring organ optimization would take effect. Patients would in fact die in the process of donating their organs (violating the currently observed dead donor doctrine). Good palliative care would meet transplantation medicine in order to transform a respectful, distress-free death into a promise of life for others in need.

It is difficult to estimate the effect of introducing organ conscription and ODE on overall organ availability rates. Savulescu and Wilkinson, for the UK, projected up to an additional 3212 organs per year for organ conscription, and 2201 organs per year for ODE (based on data from 2007 to 2008) [5]. They note though that (in the case of ODE) this would depend upon the consent rates for organ donation and how they are affected by the introduction of this alternative. For the USA, Sheehy et al. predicted that the annual number of brain-dead potential organ donors is between 10,500 and 13,800. The overall consent rate (the number of families agreeing to donate divided by the number of families asked to donate) for 1997 through 1999 was 54 %, and the overall conversion rate (the number of actual donors divided by the number of potential donors) was 42 % [6]. This means that under a policy of organ conscription the medically suitable brain-dead donors could double with an expected proportional increase in conversion rates. If we further assume that heart-beating donors yield about four organs per donor we could expect roughly over 30,000 more organs per year.

It is true that this article does not present complete arguments nor meets any of the multiple important objections, and thus does not really make a case for what is proposed. I believe that strong arguments are

available and several have been already presented elsewhere [3–5, 7–9]. Furthermore, there is much work to be done in devising relevant clinical protocols together with proposals of how to engage in the context of designing public policies. This article is intended as a call for serious, open-minded discussion of these proposals avoiding unnecessary polarization and unreflected outcries of rejection. Janet Radcliffe Richards has poignantly said that “careless thought costs lives” [10]. Careless clinical thought in the ICU certainly costs lives; we should equally realize that careless moral thought is as unacceptable, and that refusing to even discuss “radical” proposals in order to increase availability of organs can be careless, immoral, and lethal.

Compliance with ethical standards

Conflicts of interest

This manuscript has not been published elsewhere and it is not submitted simultaneously for publication elsewhere. There are no relevant conflicts of interest.

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