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EDITORIAL

Intensive Care admission aiming at organ donation. Not sure

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Setting the scene

In the realm of organ donation, the discourse is often characterised by polarising perspectives that demand allegiance to one of two opposing viewpoints: pro or con. However, within this over-simplified (dis)agreement lies a nuanced web of uncertainties. We will focus on arguments discussing a 'not sure' position regarding intensive care unit (ICU) admission finalised to organ donation—a stance that demands a careful consideration of factors contributing to its complexity [1]. We will concentrate on one scenario of organ donation; patients where brain death has not yet been determined but curative treatment is considered non-beneficial and who are thus solely admitted to the ICU for the aim to facilitate potential organ donation, also called 'non-therapeutic intensive care' [2]. Furthermore, we also focus on aspects that are always more or less relevant irrespective of country-specific particularities such as legal regulations, cultural and religious backgrounds [3]. We present our thoughts based on two relevant professional-ethical concepts: holistic care and patient- and family-centred care.

Holistic care

Holistic care encompasses body–mind–spirit [4]. Delivering care to a patient admitted to the ICU to maintain organ function for transplantation marks a transition from person to body; from 'subject' to 'object' which might feel frustrating for ICU healthcare professionals (HCPs) [5]. Holistic care is perceived as contradictory or impossible under these circumstances [6]. Thereby, HCPs perceive the risk of instrumentalising the patient and thus harming his/her dignity for the purpose of the interests of third parties which violates their self-perceived moral commitments as well as professional moral standards.

A sensitive balancing act between respecting the patients' autonomy (according to the patients' wish to become donor) and not to harm him/her with the measures necessary to prepare organ donation is needed. This might be particularly the case when the level of intensive care is high, such as extra-corporeal membrane oxygenation or renal replacement therapy [7]. After all, if it is not possible to do good to the individual patient to the desired extent, questions of distributive justice concerning scarce ICU beds arise more strongly and lead to conflicts of conscience for the HCPs as the person they are 'actually doing good to' is not their current patient but an anonymous other, namely the potential organ recipient.

On the other hand, providing dignified and humane end-of-life care for a potential donor is an opportunity for the highly skilled interprofessional ICU team experienced to express a high level of professionalism and delivering a 'good death' experience for the family [8, 9]. However, it seems to be difficult to integrate palliative care and perceptions of a good death with practices necessary for organ preservation and some nurses may feel guilty and neglectful of doing a good job [10]. Besides, following a decision of organ donation by the patient or family, in many countries the transplantation team will take over the full spectrum of care. Often this will take place in the ICU where HCPs are suddenly asked to step back and let the transplantation team do their work. Consequently, not being able or allowed to continue delivering care to the patient and family is a commonly heard frustration by ICU HCPs.

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Striving patient- and family- centred care

Family members still expect their loved one to be treated as a whole person and not a supplier of organs. The question of how this can be realised in practice for potential organ donors illustrates the dilemma: the interprofessional ICU team should enable the patient to die with dignity and at the same time care for the (potential) brain dead as if they were alive so that the organs remain in optimum condition. This dual obligation can lead to role conflicts [11] and has also significant impact on bereavement support nurses provide to family members.

Supporting families to transition to death of their beloved one is disrupted by waiting time for brain death to occur and the accompanying uncertainty as to whether it will occur at all. Even after determination of brain death, there are instances when tissue matching and finding the accurate recipient may take hours or days. This prolongation creates difficulties when the family has accepted the diagnosis and the fate of their loved one—they may be experiencing cognitive dissonance [12]. These families are waiting for the next stage which may be grieving rituals and funeral arrangements asking themselves 'when is this going to end?'. The emotional reciprocity between families and the moral/emotional burden of ICU staff adds further complexity [13, 14]. Supporting families in their suffering is extremely challenging—especially when dealing with one's own emotional ambiguity. After all, grieving of relatives is not only influenced immediately but also long-term after donation [15].

The uncertainty and reciprocal moral burden are exacerbated in situations where the patient's preferences regarding organ donation are unclear or ambiguous. The same applies to the (presumed) will of the patient to limit life-sustaining treatments—irrespective of organ donation. It makes a difference for the HCPs' and families' experiences whether the patient has explicitly, presumably or not at all, expressed the wish not to initiate ICU treatment in clinical situations in which no curative treatment can be offered due to the devastating brain damage. This also demonstrates the close connection between ethical issues and legal requirements which still need to be addressed in more detail to reduce additional sources of uncertainty.

Take-home message

First of all, a large public debate is required to promote transparency, maintain trust and to tackle misinformation that impairs advanced care planning. Second, the professional ethical standards regarding patient- and family-centred care must be considered, as must the emotional and moral toll paid by all individuals involved in these practices. The unique circumstances of the individual patient and relatives with their own needs and wishes must be considered each time anew. Above all, it is the professional duty of all healthcare professionals involved in organ donation to proactively stand-up for the moral integrity and mental health of those involved.

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Declarations

Conflict of interest
The authors declare that they have no conflict of interest.

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