

LIVES2016: Do We Need the Dead Donor Rule?



With continuing shortages of donor organs in all countries, should the dead donor rule be replaced by the “dead enough for donation” rule? The issues surrounding organ donation when the donor is not yet dead were presented by Rik Gerritsen, Chair of the [Ethics section of the European Society of Intensive Care Medicine](#) at LIVES 2016 in Milan last week.

Gerritsen noted that the dead donor rule is a legal concept that is there in effect to avoid people dying from organ donation. Interestingly, brain death as a concept was devised for prognostication, and existed before organ donation. Only later in the 1960s was brain death introduced as a concept to make organ donation possible.

Brain death is not a biological or social concept of death, it's a legal concept. Gerritsen emphasised that he considers brain dead as dead, as everything that makes a person human is not there anymore. The definition of death by circulatory criteria is also used, and is more biological and easier to understand for lay people, said Gerritsen. But he is opposed to this concept. In the Netherlands the law says that after 5 mins of cardiac arrest, a person has suffered irreversible brain damage and is declared dead. However, at the same time the Netherlands has a campaign to start resuscitation after 6 minutes. It is permanent brain death because we do not resuscitate, we need to make the distinction, he added.

The dead donor rule should be transparent, and legally and ethically defensible. But do we need this rule, asked Gerritsen. It requires autonomy (permission from the patient or family), beneficence (several others will be saved), non maleficence (death is imminent) and justice. The dead donor rule is questionable, as all patients are inevitably dying. Gerritsen argued that without the dead donor rule healthcare professionals can do a better job of end of life care and may get more and better organs.

See Also: [Care of the Multiple Organ Donor](#)

Dead enough for donation should instead be the rule, he suggested. It is ethically justifiable, integrated in better end-of-life care and will require laws to be adapted.

Improving End-of-Life Care

Speaking in the same session, Dominique Benoit offered his suggestions for improving end-of-life (EOL) care. A recent survey he conducted showed that less than 20% of participating clinicians were satisfied with the EOL decision making climate in their unit. Improving the decision making climate should be a priority both in Europe and the U.S., he said. At the intensive care unit (ICU) and hospital level are needed adequate triage criteria, an improved EOL decision making climate, a mandatory family meeting within 72 hours with the attending physician, formal training for doctors and nurses in EOL communication and an adequate patient to clinician ratio.

Triage policy should be the main focus, said Benoit, as the perception of disproportionate care is commonly held by ICU staff, and is essentially related to patients' characteristics.

At the hospital level, intensivists should be allowed to control admission and refusal, and there should be triggers at hospital admission to ensure advance care planning, particularly for patients with co-morbidities.

Improving EOL decision making at the academic level requires self-reflection and training programmes, learning the art of prognostication, both coping with uncertainty and taking evidence into account. Healthcare professionals require training in people management and communication, and there should be interdisciplinary training, including simulation, concluded Benoit.

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