La donazione a cuore fermo:

problemi tecnici e culturali

Sergio Livigni (Torino)

TRANSPLANT
INTERNATIONAL

Transplant International ISSN 0934-0874

REVIEW

Ethical, legal, and societal issues and recommendations for controlled and uncontrolled DCD

Bernadette Haase,[1] Michael Bos,[2] Catherine Boffa,[3] Penney Lewis,[4] Chris Rudge,[5] Ricard Valero,[6] Tineke Wind[7] and Linda Wright[8]

Recommendation 2:

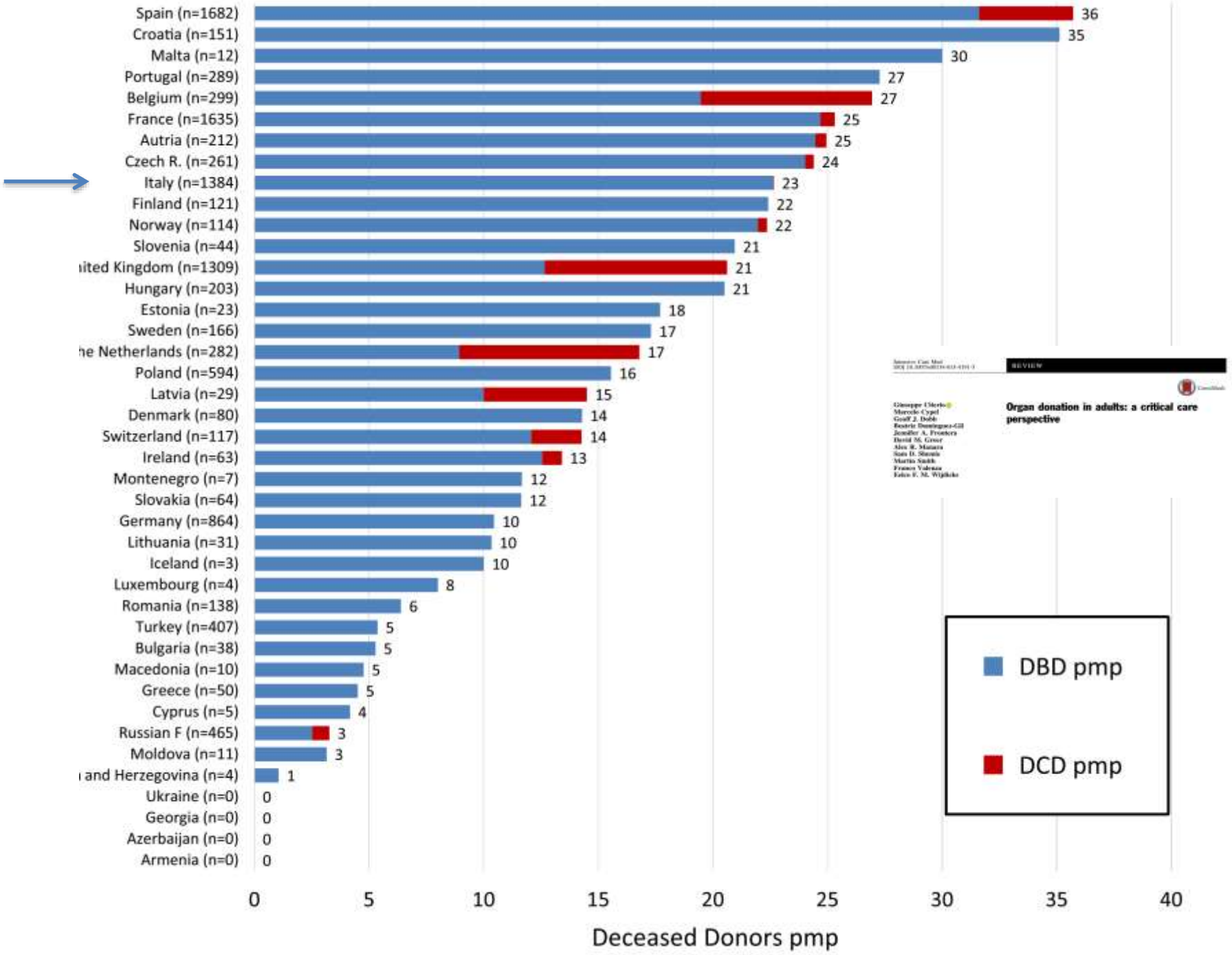
As the basis of any DCD program, there should be a clear medical, ethical and legal framework outlining when and how to decide on withdrawing or withholding life-sustaining treatment, or on the cessation of CPR. This should be based on the patient's best interests. In making these decisions each action involving that patient is justified by balancing the potential benefits and harms to that patient, also taking into account his or her wish to donate.

doi:10.1111/tri.12720

DBD (donation after brain death)

≠

DCD (donation after cardiac/circulatory death)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Croatia (n=151) 35
Malta (n=12) 30
Portugal (n=289) 27
Belgium (n=299) 27
France (n=1635) 25
Autria (n=212) 25
Czech R. (n=261) 24
Italy (n=1384) 23
Finland (n=121) 22
Norway (n=114) 22
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Hungary (n=203) 21
Estonia (n=23) 18
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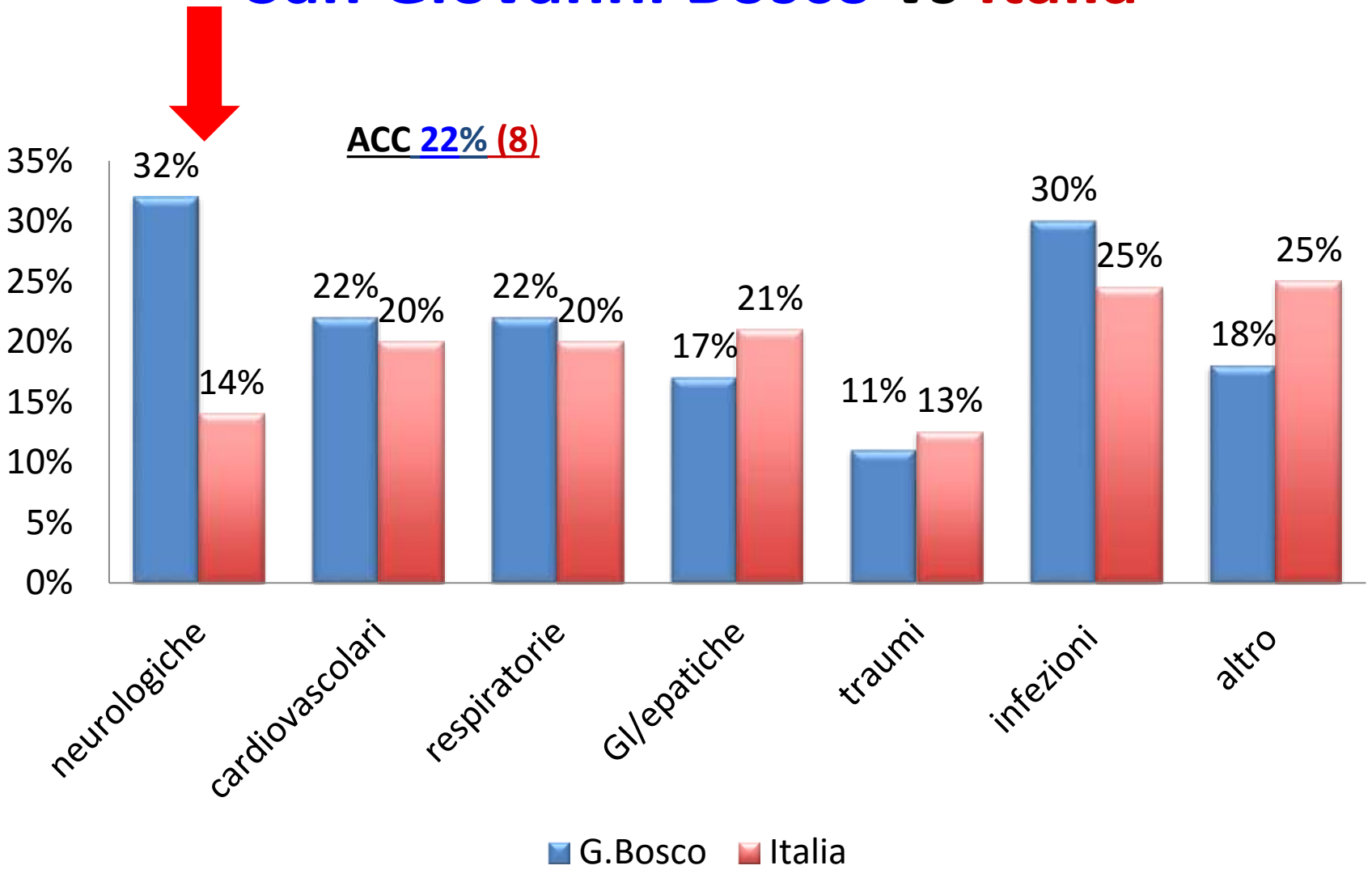
Poland (n=594) 16
Latvia (n=29) 15
Denmark (n=80) 14
Switzerland (n=117) 14
Ireland (n=63) 13
Montenegro (n=7) 12
Slovakia (n=64) 12
Germany (n=864) 10
Lithuania (n=31) 10
Iceland (n=3) 10
Luxembourg (n=4) 8
Romania (n=138) 6
Turkey (n=407) 5
Bulgaria (n=38) 5
Macedonia (n=10) 5
Greece (n=50) 5
Cyprus (n=5) 4
Russian F (n=465) 3
Moldova (n=11) 3
ı and Herzegovina (n=4) 1
Ukraine (n=0) 0
Georgia (n=0) 0
Azerbaijan (n=0) 0
Armenia (n=0) 0
0 5 10 15 20 25 30 35 40
Deceased Donors pmp
DBD pmp
DCD pmp
REVIEW
Organ donation in adults: a critical care perspective

DCD

Category	Description	Type
I Uncontrolled Unwitnessed	Sudden unexpected irreversible CA; no attempt of resuscitation by a medical team,	Uncontrolled
II Uncontrolled Witnessed	Sudden unexpected irreversible CA; unsuccessful resuscitation by a medical team	Uncontrolled
III Controlled awaiting CA	**Planned, expected CA; withdrawal of life sustaining treatment (WLST)**	**Controlled**
IV Alternative death determination	IV-A Sudden or planned CA during or after brain death diagnosis, before retrieval IV-B Death diagnosis during ECMO-ECLS by circulatory (DCD) or neurological (DBD) criteria	IV-A Uncontrolled or controlled IV-B Partially controlled

Condizioni cliniche all'ammissione 2015

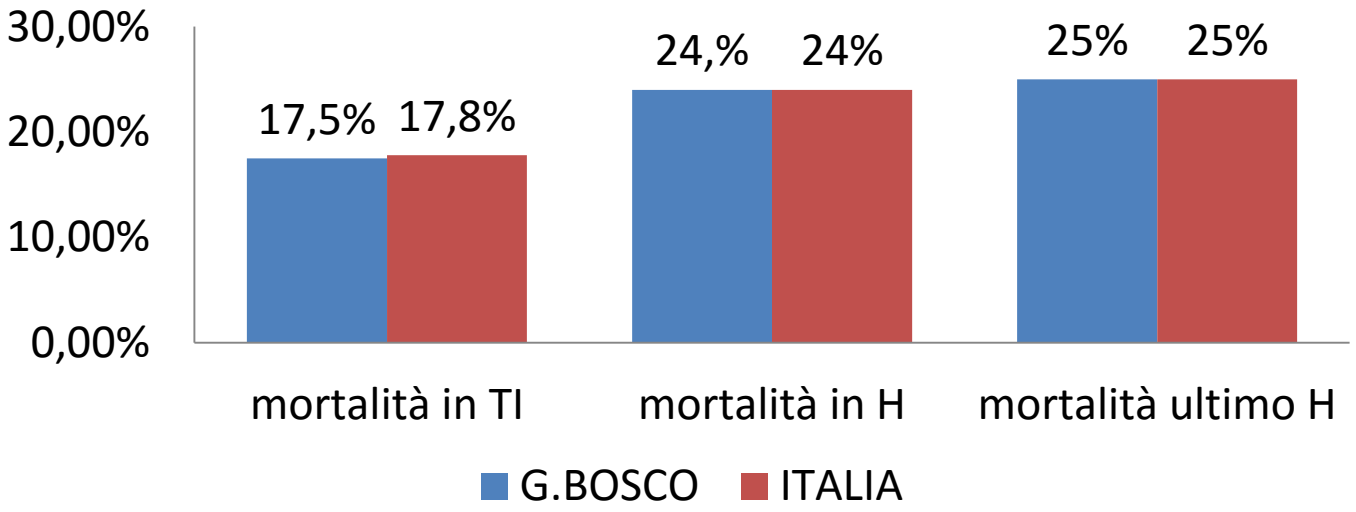
San Giovanni Bosco vs Italia



ESITI 2015

San Giovanni Bosco vs Italia

- **DECESSI in TI :** 17,5% (17,8%)
- **TRASFERITI stesso H:** 75% (73%) → **in reparto :** 58% (81)
  → **In Med Urg/UCI** 36% (8)
- **TRASFERITI altro H:** 7% (8%)
- **altro (casa,riab):** 0% (1%)
- **CAM:** 22% (9) (sui tot dei decessi)
- **MORTALITÀ OSPEDALIERA:** 24% (24)
- **MORTALITÀ nell'ultimo ospedale:** 25 % (25)
- **Riammissioni in TI :**4% (entro 48 h :26-14%, oltre 95 h : 58-76%) (3%)



Intensive Care Med (2012) 38:55–61
DOI 10.1007/s00134-011-2413-z

ORIGINAL

J. P. Quenot
J. P. Rigaud
S. Prin
S. Barbar
A. Pavon
M. Hamet
N. Jacquiot
B. Blettery
C. Hervé
P. E. Charles
G. Moutel

Suffering among carers working in critical care can be reduced by an intensive communication strategy on end-of-life practices

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Organisation

- Introduce unrestricted visiting hours
- Increase availability of the caregiving team to discuss clinical evolution and therapeutic engagement
- Assign a meeting room specifically reserved for meetings with patients' families
- Define fixed appointments with families for meetings without interruptions (physicians' telephones switched off)
- Apprise entire caregiving team of new communication strategy (defined below)
- Implement continuing medical education training in end-of-life ethics before introduction of new communication strategy
- Availability of a staff psychologist for consultation on demand

Intensive Care Med (2012) 38:55–61
DOI 10.1007/s00134-011-2413-z

ORIGINAL

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Suffering among carers working in critical care can be reduced by an intensive communication strategy on end-of-life practices

Communication

- Daily meetings of the caregiving team and with the patient and/or their family to
  - Decide on the level of therapeutic engagement (according to diagnosis, prognosis, comorbidities, previous quality of life, life expectancy, patient's wishes as expressed either directly or indirectly through advance directives)
  - Define modalities for withholding or withdrawing treatment, in accordance with the 2005 law, and initiate collegial procedure in concert with an outside expert
  - Discuss palliative care options
- Create a special "Ethics" section in every patient's medical record, accessible to all members of the team, to document all discussions and decisions relating to the level of therapeutic engagement
- Organise debriefing for members of caregiving team to discuss emotionally stressful cases
- Role-playing and round-table discussions about conflict prevention

MAKING SHARED DECISION-MAKING A REALITY

No decision about me, without me

Angela Coulter, Alf Collins

The King's Fund

Foundation for Informed Medical Decision Making

Table 1 Sharing expertise

Clinician's expertise	Patient's expertise
Diagnosis	Experience of illness
Disease aetiology	Social circumstances
Prognosis	Attitude to risk
Treatment options	Values
Outcome probabilities	Preferences

La competenza dei pazienti critici è molto spesso inadeguata al momento di dover effettuare importanti decisioni terapeutiche.

[Sprung CL, Intensive Care Med 1996; 22: 1003-1005]
[Prendergast TJ, AJRCCM 1997; 155: 15-20]
[Ferrand E, Lancet 2001; 357: 9-14]

Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

Alexander A. Kon, MD, FCCM[1,2]; Judy E. Davidson, DNP, RN, FCCM[3]; Wynne Morrison, MD, MBE, FCCM[4]; Marion Danis, MD, FCCM[5]; Douglas B. White, MD, MAS[6]

Conclusions: Patient and surrogate preferences for decision-making roles regarding value-laden choices range from preferring to exercise significant authority to ceding such authority to providers. Clinicians should adapt the decision-making model to the needs and preferences of the patient or surrogate. (*Crit Care Med* 2016; 44:188–201)

A.S.L. TO2
Azienda Sanitaria Locale
Torino Nord

PRESIDIO OSPEDALIERO
TORINO NORD EMERGENZA SAN G. BOSCO
Piazza del Donatore di sangue 3 - Torino, 10154
S.C. ANESTESIA RIANIMAZIONE B DEA
Tel 011-240.22.65 Fax 011-240.24.02
ospedale.rianimazione@asl to2nord.it

nome e cognome del paziente.....

Vi preghiamo di lasciare qui di seguito il Vostro numero di telefono e il Vostro nome, in modo che, se fosse necessario, potremmo contattarVi facilmente.

prima persona da chiamare.....numero.....

altri numeri.....

Ci sono notizie sullo stato di salute e sulle abitudini del Vostro congiunto che possono esserci utili. Vi preghiamo di rispondere, se possibile, alle seguenti domande. *Sapete se il Vostro congiunto:*

assume farmaci?.....	si	no	se si, quali.....
è allergico a qualche farmaco?.....	si	no	se si, quale.....
ha avuto qualche malattia particolare?.....	si	no	se si, quale.....
a casa la sua salute era: *eccellente; molto buona; buona; passabile; scadente*			
fuma?.....	si	no	se si, quanto.....
beve alcolici?.....	si	no	se si, quanto.....
fa utilizzo di droghe?.....	si	no	
lo ha fatto in passato?.....	si	no	
è autosufficiente nelle sue attività quotidiane?.....	si	no	
ha problemi nel camminare?.....	si	no	
ha problemi di vista?.....	si	no	

potrebbe desiderare assistenza religiosa?... sì no di che religione?.....

ha fatto testamento biologico?..... si no

è favorevole alla donazione degli organi?.... si no

11 agosto 2015

cDCD

Ospedale San Giovanni Bosco – Torino

A.S.L. TO2 *Azienda Sanitaria Locale Torino Nord* PRESIDIO OSPEDALIERO TORINO NORD EMERGENZA SAN GIOVANNI BOSCO	**Protocollo DCD** **(Donation after Circulatory Death)** prelievo di organi e tessuti a cuore fermo in donatori controllati	Data emissione	Novembre 2015
Pagina 1 di 18		Revisione n°	0
		Data revisione	

Stesura	Verifica	Approvazione
Dr. Marco Vergano Coordinatore Ospedaliero Medico per l'Attività di Prelievo di Organi e Tessuti	Dr. Sergio Livigni Direttore S.C. Anestesia e Rianimazione B – DEA	Dr.ssa Alessandra D'Alfonso SOSD Sistema Qualità e Gestione del Rischio

La donatrice

AF

- **62 anni**, **Femmina**
- 70 kg, 170 cm, BMI 24

APR

- **Nessuna** Patologia nota

APP

- **Danno cerebrale catastrofico** da emorragia intracranica massiva
- **Assenza di coscienza** e di **riflessi del tronco encefalico**
- **Minima attività elettrica residua all'EEG**

Timeline

Day O

- Emorragia in fossa cranica posteriore da sanguinamento di MAV + aneurisma PICA sx
- Ritrovata in PEA da 118 → ACLS con ROSC all'arrivo in ospedale dopo 32 minuti di RCP
- Evacuazione ematoma intracranico + clipping di aneurisma e chiusura di MAV

Day 4

- Decision to Withdraw
- Decision to Donate

Day 5

Day 6

- Introduttori
- WLST
- Donazione

- GCS 3 con assenza di riflessi del tronco
- Assenza di drive respiratorio

- EEG: Gravi anomalie diffuse con persistenza di minima reattività focale

Timeline

19:11

- WLST

Estubazione

Timeline

19:11

- WLST

19:27

- SBP <50 mmHg

19:33

- Asistolia

Estubazione

SBP <50

Timeline

19:11

- WLST

19:27

- SBP <50 mmHg

19:33

- Asistolia

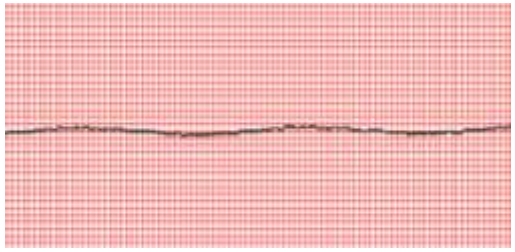
19:59

- Fine accertamento

Estubazione

SBP <50

ECG 20 minuti



Timeline

Ischemia Calda Funzionale 43’

19:11 — **- WLST**

19:27 — **- SBP <50 mmHg**

19:33 — **- Asistolia**

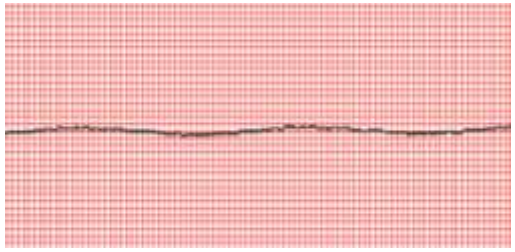
19:59 — **- Fine accertamento**

20:10 — **- NRP**

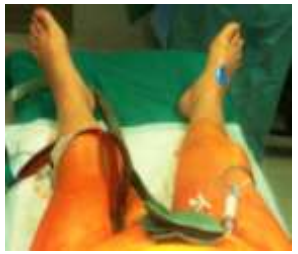
Estubazione

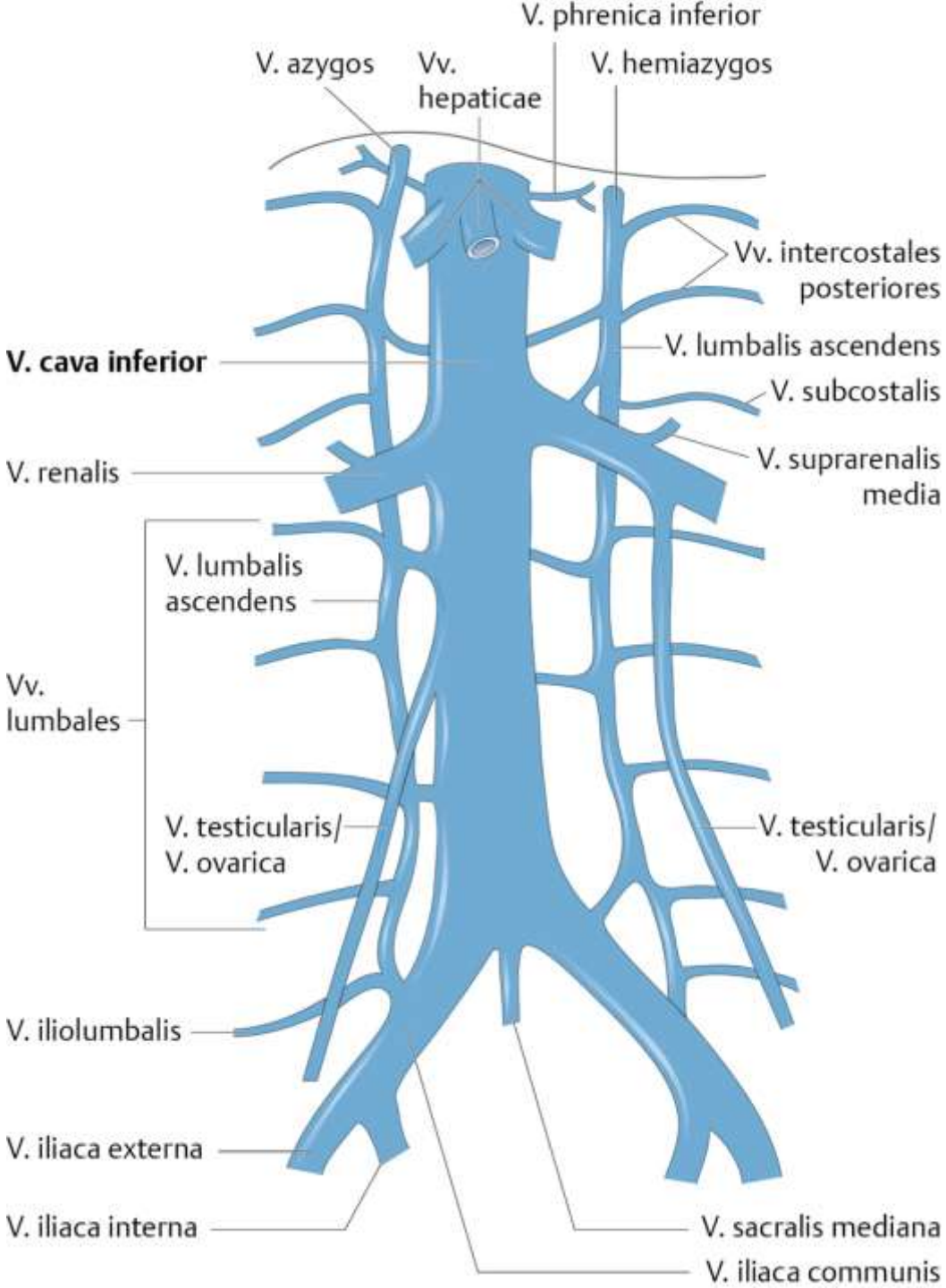
SBP <50

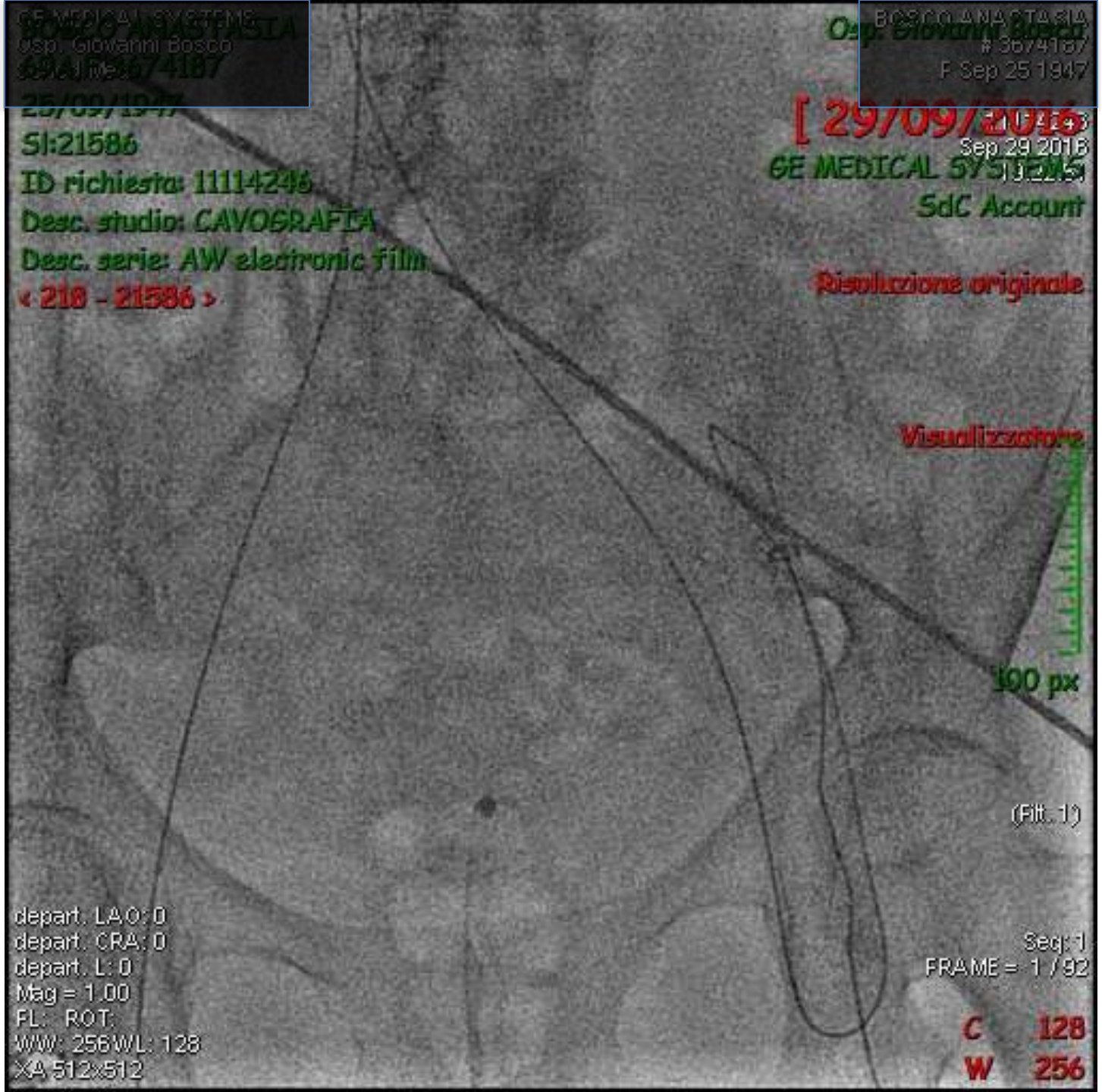
ECG 20 minuti



Incannulamento




V. phrenica inferior
V. azygos
Vv. hepaticae
V. hemiazygos
Vv. intercostales posteriores
V. lumbalis ascendens
V. cava inferior
V. subcostalis
V. suprarenalis media
V. renalis
V. lumbalis ascendens
Vv. lumbales
V. testicularis/ V. ovarica
V. testicularis/ V. ovarica
V. iliolumbalis
V. iliaca externa
V. iliaca interna
V. sacralis mediana
V. iliaca communis


Osp. Giovanni Bosco
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ID richiesta: 11114246
Desc. studio: CAVOGRAFIA
Desc. serie: AW electronic film
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Sep 29 2016
SdC Account
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Visualizzatore
100 px
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depart. LAO: 0
depart. CRA: 0
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Mag = 1.00
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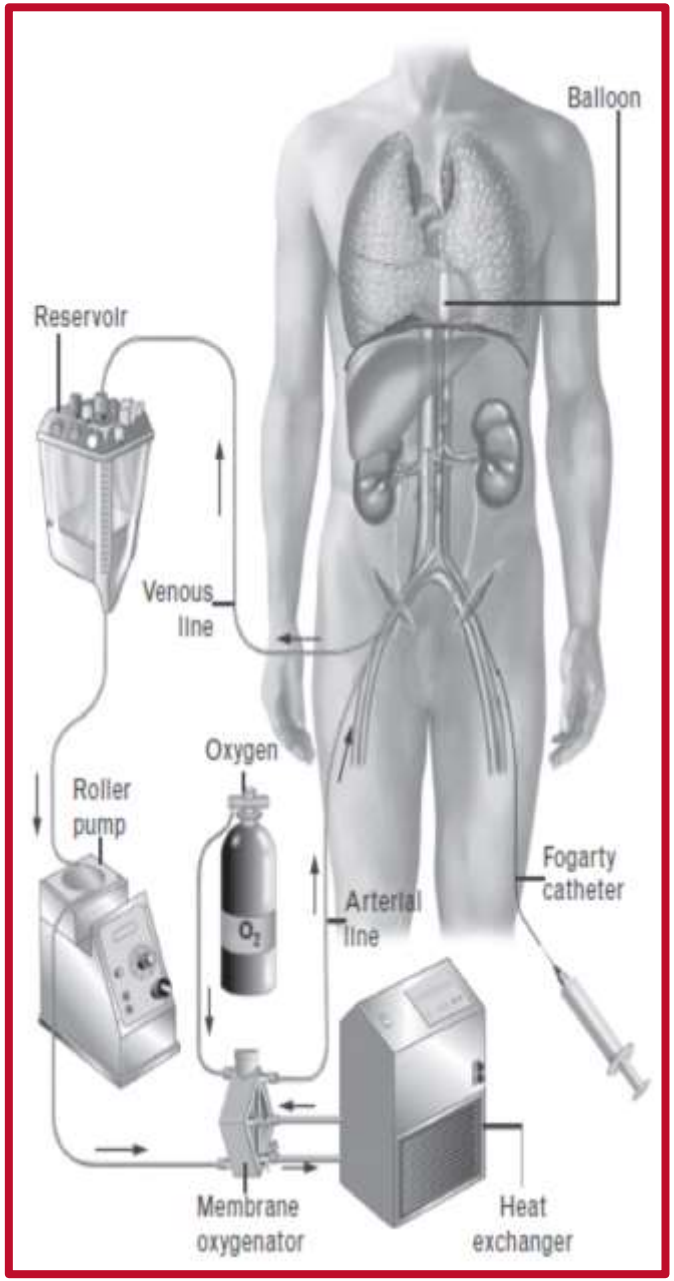
WW: 256 WL: 128
XA 512x512
Seq: 1
FRAME = 1 / 92
C 128
W 256

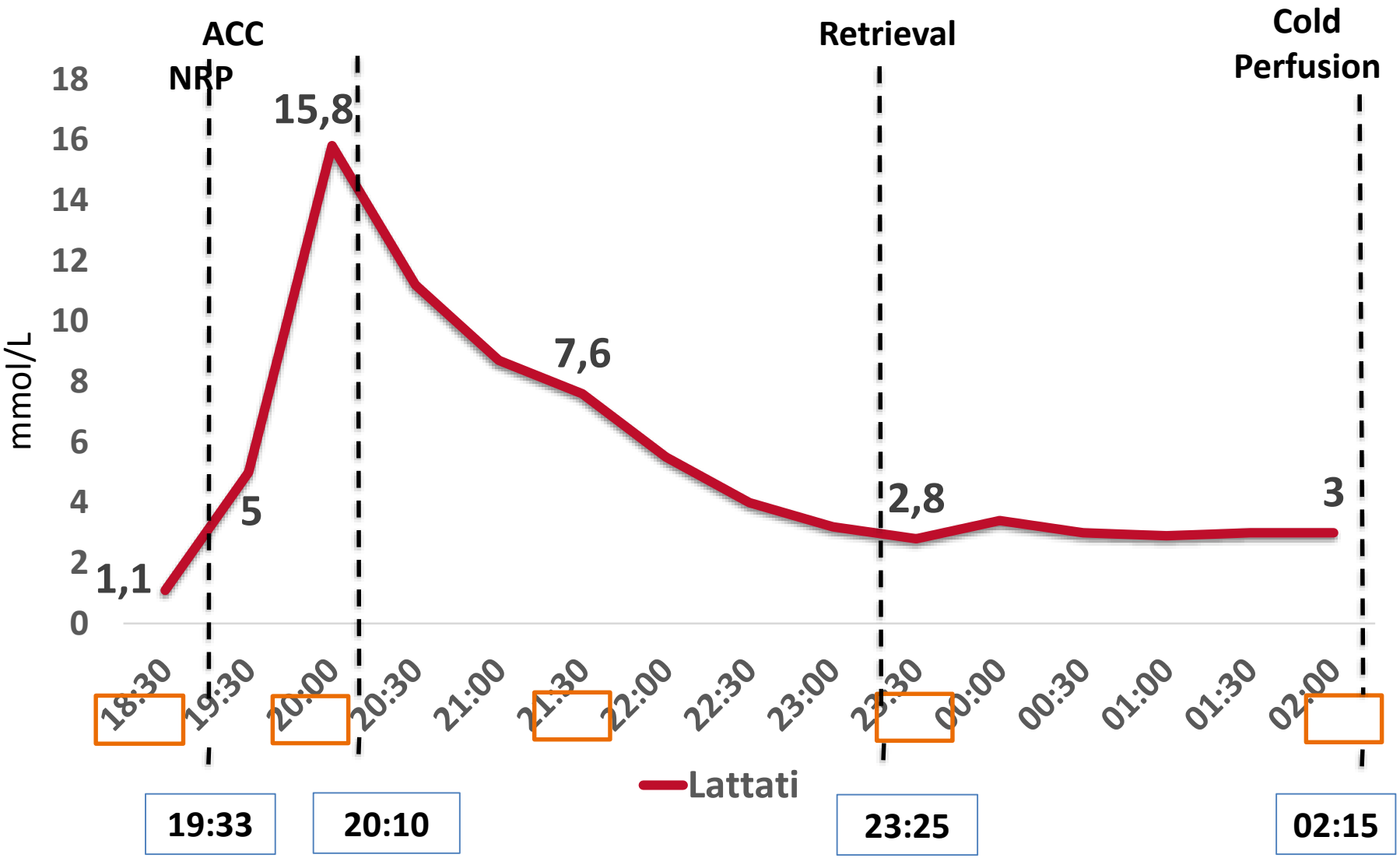
Incannulamento

- **Venoso**: 19 Fr in v. femorale sx
- **Arterioso**: 15 Fr in a. femorale sx
- **Pallone aortico** in aorta sopraceliaca (a.femorale dx)

- **Maquet Cardiohelp®**
- Flusso medio 2.5 L/min
- Temperatura 36,5 °C



Trend dei Lattati



The online version of this article is located at http://www.minervamedica.it
Minerva Anestesiologica 2016 March;82(3):359-68

EXPERTS' OPINION

"Why can't I give you my organs after my heart has stopped beating?" An overview of the main clinical, organisational, ethical and legal issues concerning organ donation after circulatory death in Italy

Alberto GIANNINI [1]*, Massimo ABELLI [2], Giampaolo AZZONI [3], Gianni BIANCOFIORE [4], Franco CITTERIO [5], Paolo GERACI [6], Nicola LATRONICO [7, 8], Mario PICOZZI [9], Francesco PROCACCIO [10], Luigi RICCIONI [11], Paolo RIGOTTI [12], Franco VALENZA [13], Sergio VESCONI [14], Nereo ZAMPERETTI [15]
on behalf of The Working Group on DCD of the Italian Society of Anesthesiology, Analgesia and Intensive Care (SIAARTI), and the Italian Society for Organ Transplantation

This urges our community to address this issue with specific educational initiatives aimed at implementing the '*SIAARTI recommendations on the management of the dying patient*' [18], to clarify the clinical and legal aspects of the end-of-life phase. This must necessarily precede any discussion on cDCD.

Tissue donation (corneas, skin, tendons, etc) is relatively frequent after deaths occurred in ICU, but we have no information to date that donation of solid organs has ever taken place in this setting. This is most probably due to cultural and organizational issues, as there are no legal constraints that could limit this approach. Such a situation is disturbing from a bioethical point of view, because organ donation could be the best way to respect the wishes of persons who want to donate their organs after death, and consequently to promote their dignity by favouring the accomplishment of their life project.

As regards the uDCD protocols, the problem seems to be less important, because life-supports (cardiopulmonary resuscitation and drug administration) are withdrawn after they have proved ineffective, i.e. unable to produce a viable recovery of spontaneous circulation.

- **Mancanza di un dibattito aperto sul fine vita**

REVIEW

End-of-life care is still a challenge for Italy

F. RUBULOTTA [1], G. RUBULOTTA [2], C. SANTONOCITO [2], L. FERLA [2], C. CELESTRE [2], G. OCCHIPINTI [3], G. RAMSAY [4]

[1]Department of Anaesthesia and Intensive Care Medicine, Imperial College, St Mary's Hospital, London, UK; [2]Department of Anaesthesia and Intensive Care Medicine, Policlinico Hospital, Catania, Italy; [3]Department of Anesthesia and Intensive Care Medicine, ISMETT, Palermo, Italy; [4]Mid Essex Hospitals Trust, Chelmsford, UK

ABSTRACT

The aim of this paper was to review current end of life (EOL) practice in Italy. The authors have made an appraisal of the existing literature in order to understand current end of life care practice in Italy. This manuscript focuses on analyzing the dying process, the transoceanic similarities and differences in the end of life decision-making practice, and the family involvement. The authors acknowledge the importance of the recent Englaro court case verdict on current practice in Italy. Dying has changed as a process over the last century in term of causes of death, costs, communication of the prognosis, and needs of the patient's family. Regardless of national and international guidelines, there is no agreement among Italian doctors regarding the gold standards of daily clinical practice at the EOL.
(Minerva Anestesiol 2010;76:203-8)

Key words: Terminal care - Palliative care - Death.

"Regardless of national and international guidelines, there is no agreement among Italian doctors regarding the gold standards of daily clinical practice at the EOL"

Intensive Care Med (2010) 36:1495–1504
DOI 10.1007/s00134-010-1910-9

ORIGINAL

Guido Bertolini
Simona Boffelli
Paolo Malacarne
Mario Peta
Mariano Marchesi
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Stefano Tomelleri
Simonetta Spada
Roberto Satolli
Bruno Gridelli
Ivo Lizzola
Davide Mazzon

End-of-life decision-making and quality of ICU performance: an observational study in 84 Italian units

Table 2 (a) Treatment plan chosen for the patient at death or discharge and (b) details of treatment limitation

	All patients (no. = 3,168)		Variability among ICUs[a]
	N	%	Median (%)
(a)			
Therapeutic support, without withdrawal/withhold decisions	1,189	37.5	30.3
Therapeutic support, without cardiopulmonary resuscitation (CPR) in case of cardiac arrest	894	28.2	26.2
Treatment limitation	1,085	34.3	40.6
(b)			
Decision to withhold	494	15.6	12.9
Intubation	85	17.2	26.8
Tracheotomy	40	8.1	25.0
Mechanical ventilation	68	13.8	21.4
Vasoactive drugs IV	269	54.5	69.2
Hemodialysis/hemofiltration	230	46.6	51.7
Surgery	68	13.8	25.0
Transfusions	78	15.8	28.6
Nutrition	41	8.3	20.0
Hydration	7	1.4	15.0
Decision to withdraw	541	17.1	20.0
Mechanical ventilation (terminal weaning without extubation)	154	28.5	32.3
Mechanical ventilation (terminal weaning with extubation)	27	5.0	13.4
Vasoactive drugs IV	377	69.7	66.3
Hemodialysis/hemofiltration	71	13.1	20.0
Transfusions	80	14.8	23.1
Nutrition	98	18.1	34.8
Hydration	22	4.1	17.1

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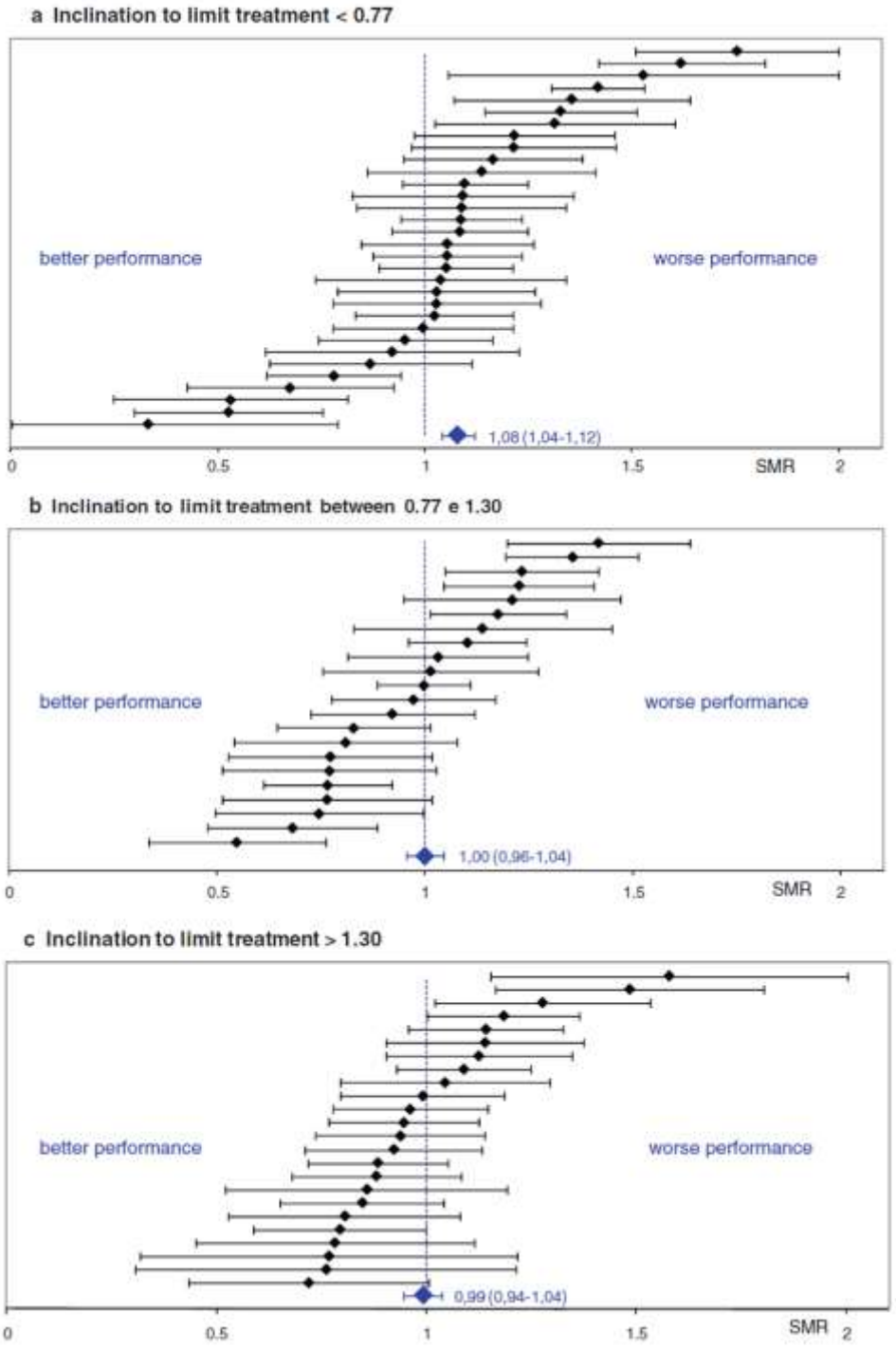
End-of-life decision-making and quality of ICU performance: an observational study in 84 Italian units

Conclusioni:
Una limitazione del trattamento è comune in Terapia Intensiva ed è principalmente responsabilità del medico. Le Terapie Intensive inclini a limitare meno i trattamenti presentano peggiori performance in termini di mortalità totale, dimostrando che la limitazione non è contro gli interessi del paziente.
Al contrario, la tendenza a limitare i trattamenti alla fine della vita può essere presa come un'indicazione di qualità nella unità.



Ethical Decision Making With End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments

MOLLY L. OLSEN, MD; KEITH M. SWETZ, MD; AND PAUL S. MUELLER, MD, MPH

Mayo Clin Proc. • *October 2010;85(10):949-954* • *doi:10.4065/mcp.2010.0201* • *www.mayoclinicproceedings.com*

TABLE. **End-of-Life Decision Making and Respective Cause of Death, Intention of Intervention, and Legality of Treatments**

	Withhold life-sustaining treatment	Withdraw life-sustaining treatment	Palliative sedation and analgesia	Physician-assisted suicide	Euthanasia
Cause of death	Underlying disease	Underlying disease	Underlying disease[a]	Intervention prescribed by physician and used by patient	Intervention used by physician
Intent/goal of intervention	Avoid burdensome intervention	Remove burdensome intervention	Relieve symptoms	Termination of patient's life	Termination of patient's life
Legal?	Yes[b]	Yes[b]	Yes	No[c]	No

[a] Note doctrine of double effect.
[b] A number of states limit the power of surrogate decision makers regarding life-sustaining treatment.
[c] Legal only in Oregon, Washington, and Montana.
From *Mayo Clinic Internal Medicine Board Review*, 9th ed.[20]

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

CRITICAL CARE MEDICINE

Simon R. Finfer, M.D., and Jean-Louis Vincent, M.D., Ph.D., *Editors*

Dying with Dignity in the Intensive Care Unit

Deborah Cook, M.D., and Graeme Rocker, D.M.

ON THE NEED FOR PALLIATIVE CARE

The coexistence of palliative care and critical care may seem paradoxical in the technological ICU. However, contemporary critical care should be as concerned with palliation as with the prevention, diagnosis, monitoring, and treatment of life-threatening conditions.

NEJM 2014;370:2506-14

Table 4. Considerations and Cautions in the Withdrawal of Life Support.*

Variable	Considerations	Cautions
Discontinuation of renal-replacement therapy	Confers a low risk of physical distress	Death may take several days if this is the only advanced life support withdrawn
Discontinuation of inotropes or vasopressors	Confers no risk of physical distress Death may occur quickly if the patient requires high doses, with or without withdrawal of mechanical ventilation	Death may not occur quickly if the patient requires low doses, particularly if mechanical ventilation is ongoing
Weaning from inotropes or vasopressors	Confers no risk of physical distress	May prolong the dying process, particularly if the patient requires low doses and this is the only life support withdrawn
Discontinuation of mechanical ventilation	Confers risk of dyspnea Death may occur quickly if the patient requires high pressure settings or high oxygen levels	Preemptive sedation is typically needed to blunt air hunger due to rapid changes in mechanical ventilation Death may not occur quickly if the patient requires low pressure settings or low oxygen levels
Weaning from mechanical ventilation	Confers low risk of dyspnea	May prolong the dying process, particularly if the patient requires low pressure settings or low oxygen levels and this is the only life support withdrawn
Extubation	Confers risk of dyspnea Avoids discomfort and suctioning of endotracheal tube Can facilitate oral communication Allows for the most natural appearance	Informing families about possible physical signs after extubation can prepare and reassure them Secretions may cause noisy breathing, which may be reduced with the use of glycopyrrolate; the use of glucocorticoids may reduce stridor Airway obstruction may occur; jaw thrust or repositioning of the patient may help Not advised if the patient has hemoptysis

LINEE GUIDA SIAARTI

MINERVA ANESTESIOL 2003;69:101-18

SIAARTI guidelines for admission to and discharge from Intensive Care Units and for the limitation of treatment in intensive care

GRUPPO DI STUDIO AD HOC DELLA COMMISSIONE DI BIOETICA DELLA SIAARTI

LINEE GUIDA SIAARTI

MINERVA ANESTESIOL 2006;72:927-63

End-of-life care and the intensivist: SIAARTI recommendations on the management of the dying patient

SIAARTI - ITALIAN SOCIETY OF ANAESTHESIA ANALGESIA RESUSCITATION AND INTENSIVE CARE BIOETHICAL BOARD

definizione di morte ≠ dichiarazione di morte

La **Legge 29 dicembre 1993, n. 578** ("Norme per l'accertamento e la certificazione di morte") stabilisce che la morte si identifica con la cessazione irreversibile di tutte le funzioni del cervello

USA

UNIFORM DETERMINATION OF DEATH ACT

§ 1. [Determination of Death]. An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

Italia

La legge italiana identifica la definizione di **morte cerebrale** come unica condizione possibile , e la definizione di **morte cardiaca** viene indicata solo **come causa sicura di morte cerebrale** .)

Intensive Care Med (2016) 42:93–95
DOI 10.1007/s00134-015-3933-8

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Heart donation and transplantation after circulatory death: ethical issues after Europe's first case

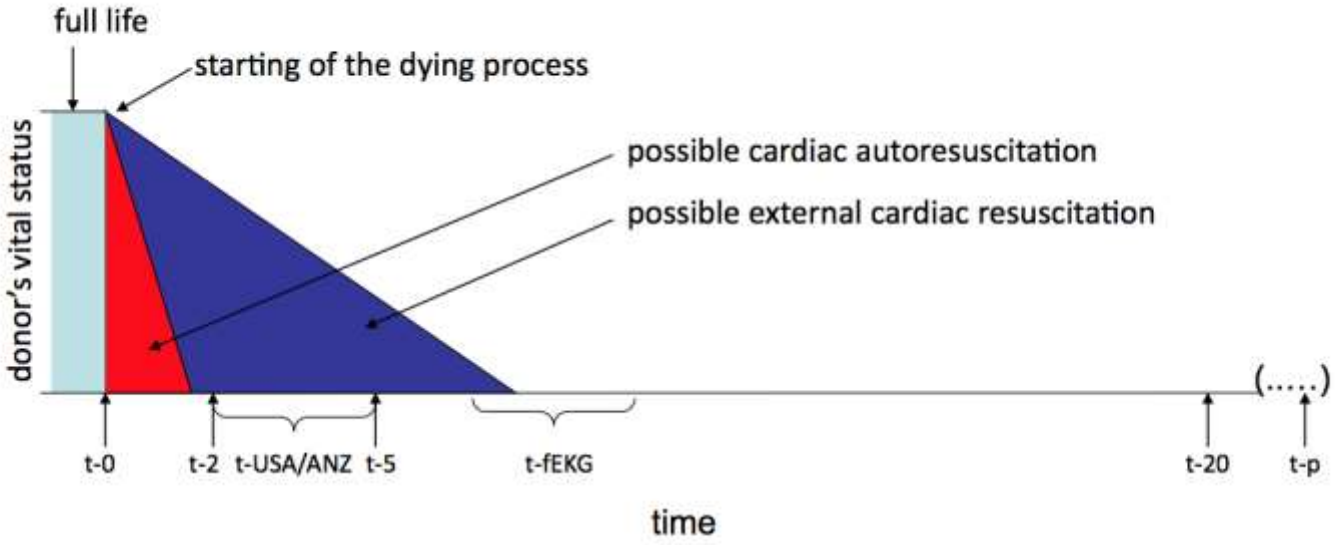

Fig. 1 The dying process in DCD. The *y-axis* represents the donor's vital status which varies from donor's full life with effective circulation (*top*) to the completion of the dying process (*bottom*). The *x-axis* is time: *t*-0: final mechanical heartbeat; rapid loss of conscience (if previously present). *t*-2: 2 min after *t*-0, asystole is spontaneously irreversible. *t*-USA/ANZ: "no-touch" period in USA, Australia and New Zealand. *t*-5: 5 min after *t*-0; "no-touch" period in Belgium, France, the Netherlands, Spain, UK. *t*-fEKG: flat EKG (electrical asystole): unpredictable, some minutes after *t*0. *t*-20: 20 min after *t*-EKG; "no-touch" period in Italy; asystole is surely irreversible; brain has surely undergone fatal and irreversible total ischaemic damage. *t-p* putrefaction (days/months)

American Thoracic Society Documents

An Official American Thoracic Society/International Society for Heart and Lung Transplantation/Society of Critical Care Medicine/Association of Organ and Procurement Organizations/United Network of Organ Sharing Statement: Ethical and Policy Considerations in Organ Donation after Circulatory Determination of Death

Cynthia J. Gries, Douglas B. White, Robert D. Truog, James DuBois, Carmen C. Cosio, Sonny Dhanani, Kevin M. Chan, Paul Corris, John Dark, Gerald Fulda, Alexandra K. Glazier, Robert Higgins, Robert Love, David P. Mason, Thomas A. Nakagawa, Ron Shapiro, Sam Shemie, Mary Fran Tracy, John M. Travaline, Maryam Valapour, Lori West, David Zaas, and Scott D. Halpern; on behalf of the American Thoracic Society Health Policy Committee

A central **ethical and legal challenge** in DCDD is to determine the **timing of death** for patients who die after the withdrawal of life-sustaining treatment. This is important because established ethical and legal standards subscribe to the "**dead donor rule**", which states that removal of organs for transplantation must not precede the death of the organ donor. Defining the timing of death is also important because the duration of ischemia before organ recovery is closely related to the viability and quality of transplantable organs.

From a biological perspective, **dying is a process** that occurs over a continuum of time. But in the context of DCDD, the **tension between the need for both "live organs" and a "dead donor"** has required the development of very explicit criteria for declaring the **"moment" of death**, despite the **absence of a biological basis** for this degree of precision.

Am J Respir Crit Care Med Vol 188, Iss. 1, pp 103–109, Jul 1, 2013

This urges our community to address this issue with specific educational initiatives aimed at implementing the '*SIAARTI recommendations on the management of the dying patient*' [18], to clarify the clinical and legal aspects of the end-of-life phase. This must necessarily precede any discussion on cDCD.

Tissue donation (corneas, skin, tendons, etc) is relatively frequent after deaths occurred in ICU, but we have no information to date that donation of solid organs has ever taken place in this setting. This is most probably due to cultural and organizational issues, as there are no legal constraints that could limit this approach. Such a situation is disturbing from a bioethical point of view, because organ donation could be the best way to respect the wishes of persons who want to donate their organs after death, and consequently to promote their dignity by favouring the accomplishment of their life project.

As regards the uDCD protocols, the problem seems to be less important, because life-supports (cardiopulmonary resuscitation and drug administration) are withdrawn after they have proved ineffective, i.e. unable to produce a viable recovery of spontaneous circulation.

Susanna Valpreda
prima ideatrice
di queste Giornate

Torino,
sabato 26 novembre 2016
Aula Magna del CLE (Campus Luigi Einaudi)
Lungo Dora 100, Torino

Autonomia alla fine della vita:
limitazione delle cure, eutanasia e altre forme del morire

La situazione mondiale riguardo la centralità dell'autonomia della persona nelle decisioni di fine-vita è in continua e rapida evoluzione, così come sul tema sta evolvendo il quadro legislativo di molti Paesi. Purtroppo in Italia sono stati fatti pochi progressi dal ddl Calabrò del 2009 e il dibattito in materia rimane stagnante. Agli inizi di quest'anno 2016 il Parlamento ha cominciato l'esame delle proposte di legge sulle direttive anticipate di trattamento, ma il processo appare lungo e tortuoso, anche perché le prospettive sul tema sono ancora significativamente diverse.
Viviamo un contesto incerto in cui gli orientamenti politici possono portare a risultati inattesi sia nel senso di un ritorno all'impostazione tradizionale in linea col ddl Calabrò, sia nel senso opposto di aperture a impostazioni innovative come in Olanda e ora in Canada. Diventa interessante tornare a riflettere sul ruolo che l'autonomia della persona (e del curante) ha alla fine della vita: alla luce dei cambiamenti intervenuti o in corso in altri paesi, diventa urgente focalizzare l'attenzione sui problemi posti dalla limitazione delle cure, dalla sedazione palliativa e anche dalle altre forme del morire come il suicidio medicalmente assistito e l'eutanasia.
Il Convegno intende fare il punto della situazione al fine di chiarire alcuni dei principali temi in gioco e offrire spunti di riflessione per l'apertura di nuovi orizzonti nel settore.

08.00 Registrazione dei partecipanti

AUTONOMIA, ETICA, E LIMITAZIONE DELLE CURE

Presiede **MAURIZIO MORI**

08.30 Apertura del Convegno e saluti delle autorità

09.00 **SERGIO LIVIGNI** - Rianimatore, Torino
La limitazione delle cure come dovere etico e deontologico: problemi e prospettive

09.20 **PIERGIORGIO DONATELLI** - Bioeticista, Roma
Autonomia e controllo democratico del morire

09.40 **LUCA SAVARINO** - Bioeticista, Torino
Il rapporto medico-paziente alla fine della vita nel contesto dell'autonomia

10.00 Dibattito con il pubblico

10.20 Pausa

PROBLEMI DI FINE VITA: FILOSOFIA E CLINICA A CONFRONTO

Presiede **MAURIZIO MORI**

10.50 **MAURIZIO CALIPARI** - Bioeticista, Roma
Perché moralmente non si deve rendere accessibile l'eutanasia?

11.10 **DEMETRIO NERI** - Bioeticista, Messina
Perché moralmente si deve rendere accessibile l'eutanasia?

11.30 **MARIA TERESA BUSCA** - Bioeticista, Torino
Le esperienze nel mondo (Olanda, Belgio, Svizzera e Nord America) circa la morte assistita

11.50 Dibattito con il pubblico

12.10 **PAOLO MALACARNE** - Rianimatore, Pisa
Quando il malato è il grande assente

12.30 **GIORGIO VITTORIO SCAGLIOTTI** - Oncologo, Torino
Quale autonomia quando non c'è più la possibilità di scegliere una terapia?

12.50 **MARCO VERGANO** - Rianimatore, Torino
Cure intensive e fine vita

13.10 Dibattito con il pubblico

13.30 **MAURIZIO MORI** e **SERGIO LIVIGNI**
Conclusione dei lavori

Direzione scientifica
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La partecipazione al Convegno è gratuita
È stato richiesto l'accreditamento ECM per tutte le professioni sanitarie
Si prega di effettuare l'iscrizione entro il 20 novembre al seguente indirizzo email: gornatedibioetica@libero.it

L'evento è patrocinato da Consulta di Bioetica onlus, DFSE (UNITO), GRB-TO ed è sponsorizzato dalla ditta Maquet