Authors have nothing to disclose with regard to commercial support.

AN ETHICAL JUSTIFICATION FOR THE WITHDRAWAL OF VENTRICULAR ASSIST DEVICES

To the Editor:

In their recent article, Entwistle and Fenton¹ correctly note that a patient who is physiologically well after ventricular assist device (VAD) placement but who experiences extreme existential distress presents ethical and legal problems. They conclude that because a patient with a VAD does not have a terminal illness, removal of the device under any circumstances is “more akin to ‘killing’ than ‘allowing to die.’”¹

The suggestion that disconnecting a VAD is the same as killing a patient is troubling. There exists a morally (and legally) significant difference between killing patients and allowing them to die naturally of underlying disease. The crux of the authors’ distinction between the 2 rests on the new physiologic condition of aortic insufficiency created when a VAD is inserted and subsequently turned off. In doing this, according to the authors, a new “lethal condition” has been created and therefore, meets the definition of killing rather than letting a patient die of his or her pre-existing condition. However, VADs are placed in patients with end-stage heart failure who, without intervention, would be considered terminally ill. The physiologic changes created by the VAD do not change the fact that the patient has an underlying terminal illness, and without the life-sustaining support of the VAD, would die in a short period of time. Although aortic insufficiency caused by the deactivation of a VAD may hasten death, a patient is ultimately dying of his or her underlying heart failure. The aortic insufficiency is a very narrow, technical view of the cause of death and should not negate the ethical justification for removing a patient’s VAD.

Additionally, Entwistle and Fenton¹ suggest that a patient could avoid asking for physician assistance by simply disconnecting a VAD’s power supply at home to end his or

her life. This is unacceptable because the symptoms caused by cessation of VAD support must be managed carefully. The authors say a prescription for anxiolytics or narcotics to “ease the pain or anxiety associated with this process” is reasonable¹; however, the doses that would be prescribed to an outpatient are unlikely to adequately treat symptoms such as dyspnea and chest pain that occur when the machine stops. It is unethical to force patients to suffer at the end of life without appropriate palliative care or medical supervision.

We certainly do not suggest that the discontinuation of a VAD is permissible in any kind of circumstance. However, it is possible that despite best medical efforts and emotional support, patients may find their lives so severely limited that they would reject the ongoing life support provided by a VAD. In fact, a recent study showed that 6 months after successful VAD implantation, 20% would not agree to VAD placement if they could make the decision again.² Under such convincing circumstances, physician compliance and supervision with removal of life-sustaining VAD therapy should be considered ethically justifiable.

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<https://doi.org/10.1016/j.jtcvs.2020.01.075>

REPLY: DEATH IS SAD, BUT NO ONE’S BAD TO STOP A VAD

Reply to the Editor:

Fischkoff, Nakagawa, and Blitzer¹ criticize Entwistle and Fenton’s article² on several grounds. I believe their criticisms are valid. The patient does indeed have a terminal condition: his underlying heart failure. Entwistle and Fenton² rely on Sulmasy’s definition of killing, but they offer no justification for adopting a single, narrow

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