Is consideration of organ donation good practice in end-of-life care?

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Terminal prognosis due to neurologic or lung insult

**Exam c/w brain death**

- **Pronouncement on neurological criteria**
- **Family approached, consent established and/or sought**
- **Surgical recovery of organs**

**DNDD**

- **EOL Care**

**Controlled DCDD**

- **Exam not c/w brain death**
- **Family decides to withdraw life-sustaining therapies (LST)**
- **Family approached, consent sought**
- **LST withdrawn (in OR)**
- **Pronouncement (circ)**
- **Recovery of organs**

**Uncontrolled DCDD**

- **Sudden cardiac arrest**
- **Decision to terminate CPR**
- **Consent established and/or sought while prepping to procure**
- **Cease CPR**
- **Pronouncement (circ)**
- **Recovery of organs**

**EOL Care**
Carol
Threats of donation to quality of EOL care

- Uncertain role of ‘first-person consent’ (DNDD & DCDD)
- Mitigation of trust (DNDD & DCDD)
- Inadequate time or training to provide optimal EOL care (DCDD > DNDD)
- Separation of family (DCDD > DNDD)
- Unrealized hope (DCDD > DNDD)
Donation may improve EOL care quality

• **Families**: “something good has come from our loss” (DNDD & DCDD)

• **Patients**: promoting genuine interests as *sine qua non* of quality EOL care (DNDD & DCDD)

• **All**: preserve opportunity to donate without extending suffering (DCDD)
Perceptions of organ donation after circulatory determination of death among critical care physicians and nurses: A national survey*

Joanna L. Hart, MD; Rachel Kohn, MD; Scott D. Halpern, MD, PhD

A 50-year-old male is admitted to your ICU with non-recoverable anoxic brain injury following resuscitation for sudden cardiac arrest at home. After 48 hours in the ICU, he remains intubated and unresponsive. He is not brain dead. He is hemodynamically stable and all other organ systems are intact. The patient’s driver’s license states that he would like to be an organ donor.** He has no advanced directive, but his wife says he would want life-sustaining therapies withdrawn in this situation. The wife also asks whether he could become an organ donor.*** For this patient to become an organ donor, you and the attending physician would stop all restorative therapies and have him transferred to an operating room where you would extubate him and provide palliative sedation at your discretion. If respiration and circulation ceased within 60 minutes, and remained absent for > 2 minutes, the physician would declare death and you would both leave. Surgeons would then procure his organs.

a) “ICU nurses**** should help this patient become an organ donor in the ways described above.”
b) “Promoting organ donation in this case would conflict with the ICU nurse’s**** other duties to this patient.”
c) “Helping this patient become an organ donor would improve the quality of his end-of-life care.”

- 684 of 2,206 academic ICU physicians (31%)
- 438 of 988 ICU nurses randomly selected from AACN (44.3%)
‘Helping a patient become an organ donor would improve end-of-life care’

RNs (55%) more likely than MDs (33%) to agree that EOL would be promoted (p < 0.01)

Presence of donor designation increased odds of favorable views:
  MDs: 1.74 (1.18-2.57)
  RNs: 1.37 (0.96 – 1.95)

No influence of family (vs. OPO) requesting donation

Overcoming the threats of donation to EOL care
Informed consent process

Discussion of interventions to promote organ quality

In DCDD, surrogates also should be informed about:

1. how and where life-sustaining therapies will be withdrawn
2. time they can spend with their loved one post-mortem
3. possibility that patient may not die within the DCDD time interval
4. how and where patient will be cared for if donation does not occur

ATS-SCCM-ISHLT-UNOS-AOPO Ethical and Policy Considerations in Donation after Circulatory Determination of Death. AJRCCM (in press)
“Those caring for potential DCDD donors should demonstrate core competencies in...”

- communicating openly and clearly with families, other ICU team members, and OPO staff
- withdrawing unwanted life-sustaining therapies quickly and without precipitating distress
- managing symptoms of pain, anxiety, and breathlessness
- providing emotional and spiritual support for bereaving families
Donors After Cardiac Death: Validation of Identification Criteria (DVIC) Study for Predictors of Rapid Death

M. A. DeVita, M. Mori Brooks, C. Zawistowski, S. Rudich, B. Daly, and E. Chaitin

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Operating characteristics of model:
Sens: 79%
Spec: 63%
PPV: 63%
NPV: 78%

sustaining treatment (LST) are regularly deemed unsuitable for DCD. Organs from DCD generally function nearly as well as those from brain-dead donors, and so are worth the effort and expenditure (4,5). One difficulty in ‘identifying’ the DCD candidate has been the lack of reliable criteria for predicting death within 60 min of withdrawal of LST. A United Network for Organ Sharing (UNOS) DCD consensus committee developed such criteria (Table 5) based on expert opinion and scant data. The criteria have not been validated as yet, and their utility is therefore suspect.

CART analysis of key patient variables at time of WLST:
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‘Consideration’ not rate-limiter

Minimal data

Most likely

Hard to expand knowledge

What is ‘good’ EOL care?
Back to Carol
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