Is There a Role for Single Non-Vital Organ Donation Prior to Withdrawal of Support?

Case Study +

Critical Care Staff Perceptions

The Rev. Dr. Donald Stouder
Lifesharing + UNOS Ethics Committee
**definition** n. 1.

The teacher gave definitions of the new words.
The 2 Worlds of Donation

DECEASED ORGAN DONATION

LIVING ORGAN DONATION
Third World Needed??

IMMINENT
DEATH
ORGAN
DONATION
Hartford Hospital

- Large 867 bed urban tertiary care center
- Level 1 Trauma Center
- Transplant Center
  - Kidney
  - Liver
  - Heart
- 5 ICUs
Case Presentation

• 60 y.o. Female
• Extensive SAH 2$^0$ ruptured aneurysm
• Futile prognosis shared with family
• Inquiry from family re: donation options
•Registered Donor
Family wanted to follow patient’s frequently stated wish to be a donor

1. Wait for brain death

2. Attempt DCD

3. Imminent Death Donation: donate one kidney as living donor prior to withdrawal of support

“IDD”
Urgent Ethics Committee Meeting Re: IDD

• Guiding principles
  – Precedence (w/in community of practice)
  – Respect for patient autonomy
  – Respect for surrogate substituted judgment
  – Beneficence
  – Justice
  – Doctrine of double effect
Imminent Death Donation: Outcome

• Ethics Committee deemed IDD ethically sound in this case.
• IDD option offered to family; discussed with tx surgeons
• Kidney accepted by transplant surgeon for 0 MM
  – Recipient patient unavailable
  – Case did not proceed
• Patient declared brain dead 24 hours later
  – Kidneys and liver allocated
  – Intra op exam reveals lung malignancy
Lessons Learned

• More questions than answers
  – Adequate malignancy screening?
  – Billing and reimbursement for procedures?
  – Allocation process...living altruistic vs. deceased donor?
  – Living vs. deceased donor protocols?
  – What if patient dies in OR?
  – What if patient doesn’t die imminently?
  – Statistical nightmare...living donor death
  – Hospital staff and public perception issues

• Not ready for prime time...
Any Published Cases?

Should IDD Be Another Donation Option?

• Electronic survey sent to 462 critical care staff
  @ HH
  – MDs
  – APs
  – RNs
  – RCPs
  – Social Work & Pastoral Care

• 210 complete responses (46%)
Survey

• Defined IDD
  – Donation of a single non-vital organ or organ segment from an individual prior to his/her expected death

• Demographic questions

• Personal experience with donation/transplantation
Demographics

210 respondents:
19.0% male,
81.0% female
Years in Practice

Mean = 13.85 years  Range = 1-47 years
Registry Status & Personal Donation Experience

31.4% had some donation/tx personal experience
Survey Case Scenario

- Devastating brain injury
- Not brain dead nor likely to become BD
- Not likely to expire to allow DCD
- Advance directives re: aggressive care not desired given grim prognosis
- Patient wishes re: donation unknown
- Family hoped donation could occur
If you were the scenario patient, what would you like your NOK to do?

**IDD**: Give consent for you to donate one organ or organ segment prior to your expected death

**WOS**: Remove your life support without organ donation

![Bar chart showing 88.1% of respondents choosing IDD and 11.9% choosing WOS]
If NOK was the scenario patient, would you consent to IDD for them?
Impact of Registry Status on “Yes” to IDD

- Registered: 92.8%
- Non-Registered: 69.8%
- IDD For NOK: 39.5%

*p<.001*
Concerns

Avg: 1.07 range 0-5
Concern Comments

• Public trust may be compromised
• Lots of public education needed!
• “Slippery slope”
• Chance of neurologic recovery and/or ultimate survival
• Registry option may decrease registrations due to confusion & distrust
• Difficult concept for families to deal with at such a difficult time
• Surgical complications
• Legal implications
Survey Summary

• General favorable response to IDD for self
• Less favorable response to IDD for others
• Only 4% felt consent for IDD should never be given
• Most felt surrogate consent could be considered for living organ donation
• Nearly 50% felt surrogate consent only adequate
• Nearly 30% felt more than surrogate consent needed
  – Verbal wishes—70%
  – Self designation—60%
Survey Summary

• Most felt IDD not in violation of religious or moral beliefs
• Post-op pain concerns would not prevent most from giving consent for IDD
• More than 60% felt ok with surgical procedure that does not benefit the live patient
• Perception that the decision re: IDD may cause undue stress for the surrogate or NOK quite strong: 58% agreed/strongly agreed
• More than one third indicated concern re: IDD being performed under inappropriate circumstances
• Most felt IDD should be added as an option when registering as an organ/tissue donor
Safeguards

• Non-vital organ only
• After decision to withdraw life support independent of organ donation
• Death expected shortly after w/d life support
• Evidence that pre mortem recovery offers advantage over post mortem
• Public education: mechanism to indicate individual preference
• Legal consent
• Surrogate must understand process and implications
• Recovery consistent with patient’s preferences
• No financial compensation to surrogate
• Organ should not go to surrogate or family member or through organ exchange programs (conflict of interest)

Wendler D. Assessing the ethical and practical wisdom of surrogate consent for living organ donation. JAMA 2004; 291: 732-735
Policy for Process and Procedure

- Notification of OPO re: end of life discussions and possible impending w/s life support

- Eligibility
  - Patient not BD
  - Independent decision to w/d life support
  - Does not meet criteria for DCD
  - Designated organ/tissue donor and/or family wishes organ donation
  - Patient expected to survive kidney recovery surgery
  - Organ segment or kidney suitable for transplantation
Policy for Process and Procedure

• Procedure
  – Patient and kidney (organ segment) determined to be suitable for IDD
  – Orders written to maintain organ perfusion
  – Written documentation of decision by surrogate/NOK to w/d life support
  – Consultation with Ethics and Palliative Care Services
  – Option for IDD presented to surrogate/NOK
    • Risk of surgery, need for further testing, assessment by anesthesia, financial considerations
  – OPO screens for IDs and blood type (serology)
  – Transplant program rep determines additional necessary screening tests
  – OPO and Transplant program rep conduct PMH screening, and Medical/Social History questionnaire
Policy for Process and Procedure

- Procedure
  - Ongoing medical management of donor by intensivist team
  - Allocation based on UNOS and Transplant Program placement policies for non-directed living donor organs
  - IDD kidney procurement surgery conducted in accordance with UNOS and Transplant Program policies for living (kidney) procurement
Policy for Process and Procedure

• Post-operative phase
  – Patient transported by Transplant Program rep postoperatively to ICU of origin
  – W/D life support will not occur until minimum of 6 hours post-op and after qualified anesthesia provider documents patient’s recovery from anesthesia
  – Patient’s medical care directed by ICU attending
  – W/D of life support in ICU directed by ICU attending and/or Palliative care
  – Patient may require transfer to Hospice/Palliative care floor post w/d life support
Discussion: When to Offer?

- Only after surrogate decides to withdraw life support
- Hemodynamically stable
- As alternative to waiting for brain death
- As alternative to questionable DCD candidate
  - May not die in time required (25-35% of DCD donors)
  - Can guarantee one good organ vs. none or less well functioning organs
- Only to those surrogates that inquire about donation
- Directed donation only
- Registered patients only
Discussion

• Should surrogates be given the right to make this decision regardless of registry status?
• Does IDD benefit the donor? Does it need to?
• Equal and fair distribution?
  – What about pts at hospitals w/o transplant centers
  – Living organ donation only happens at transplant centers
  – Transfer pt to transplant center for donation only?
  – Change UNOS policy to allow transplant surgeons to recover IDD organ at all hospitals?
• Impact on public trust?
• Slippery slope perception?
Clinical Concerns

- Potential pain to donor
- Risk of death intra-operatively
- What if patient survives without life support?
- Donor evaluation criteria: same as for living donor?
  - Avoid negative impact to donor in case of survival
  - Avoid negative impact to recipient (malignancy from donor)
    - Can’t examine body cavities @ recovery
    - Colonoscopy, mammography, CT scans?
Logistics

• Allocation
  – Non-directed living donor hospital list (transplant center)?
    • Is this fair?
  – Deceased donor list?
• What should payment process look like?
  – OPO recovery staff and coordinators vs. tx staff
  – Extra ICU time post recovery from anesthesia
• Anesthesiologist issues?
  – Are there any?
  – What are they?
• Transplant center issues?
  – Surgeons
  – Living donor mortality rate (UNOS)
    • Would need to be separate category
Next Steps

- Create a process on hospital level to proceed on case-by-case basis
- Multi-center survey?
- Survey other hospital staff and/or public?
- Goal of IDD becoming standard donation option
  - Consensus Conference
Ready for Prime Time?

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