

Donation after Cardiac Death: An Ethical Reflection on the Development of a Protocol

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BOTH CMS AND THE JOINT COMMISSION have recently mandated that all hospitals develop a protocol in conjunction with their local organ procurement organization that outlines the procedures by which organs can be harvested after cardiac death. The mandate was issued in the expectation that more organs, particularly kidneys and livers, will be available for patients who will die without such transplants. Clearly, the goal of increasing the number of organs available for transplantation is important to providing care for patients with liver and kidney disease; indeed it is a significant social goal. However, this new mode of organ donation should occasion some significant ethical reflection within the health care community as we proceed to the implementation of these new protocols.

Until recently, most livers, kidneys and hearts have been transplanted from brain dead bodies. The deceased was declared brain dead, but the respirator and other medical interventions were kept in place so that the organs continued to be perfused until the moment of their removal from the body. The basic ethical principle that justified this type of transplantation was the dead donor rule. By medical, legal and ethical standards the entire procedure was performed on a dead body.

Abandoning dead donor rule

As Troug and Cochrane have pointed out, donation after cardiac death marks the abandonment of the dead donor rule. (Robert Troug and Thomas Cochrane, "The Truth about Donation after Cardiac Death," *The Journal of Clinical Ethics* 17, No. 2: 133-38). They contend that it is medically uncertain whether the donor is permanently and irreversibly deceased at the time of transplantation. Donors, they assert, "are dying but not yet dead" (p. 138). Their point is not that donation after cardiac death is ethically reprehensible, but, rather, that the dead donor rule is an inappropriate standard. The criteria that justify organ transplantation should be the patient's prognosis and the patient's consent. Thus, given the appropriate consenting

process, immanently dying patients become potential donors for transplantation after cardiac death.

In her excellent anthropological study of death in American hospitals, Sharon Kaufman has documented the way in which natural death has been supplanted by death by choice (*And a Time to Die: How American Hospitals Shape the End of Life*, Scribner 2005). The death of the immanently dying in hospitals is not simply the result of natural processes, but, rather, the result of decisions by physicians and family members to remove a respirator and/or step down treatment so that death occurs as the result of the absence of life-supporting technology. As choice marks the transition between life and death, the possibility of identifying potential donors for donation after cardiac death becomes easier. The rationale for the abandonment of the dead donor rule becomes patent.

If transplantation medicine has come to the point that it is appropriate to abandon the dead donor rule, and if American society concurs in that judgment, then we must also acknowledge that potential donors are still living, that their human dignity remains intact and that they are owed, like all other vulnerable persons, ethical and medical respect. What becomes important is to craft canons of ethical respect appropriate to their particular vulnerability.

Questions of consent

Many Americans indicate at the time of their driver's license renewal their willingness to be organ donors. They do so with absolutely no foreknowledge of the conditions under which their death may ultimately occur. Is such a level of consent when coupled to a prognosis of immanent death sufficient to classify them for donation after cardiac death? When measured against the consenting process of a patient for even a minimally invasive procedure, to say nothing of the consenting process for major surgery or a research protocol, the consent represented on a driver's license seems to fall far short of the appropriate ethical standard.

Some individuals who consent to transplantation on their driver's license also have living wills that indicate they do not want to be resuscitated or intubated if they are imminently dying, if they have such a poor prognosis. If such a person becomes an imminently dying patient, should the living will or the consent on the driver's license prevail? Which document more clearly construes the person's moral choice in the light of immanent death?

Ultimately, this is a legal issue, but a legal issue that needs to be resolved in the context of ethical considerations. One solution would be to provide sufficient information to persons at the time of license renewal so that they have an adequate understanding of what they may be consenting to. Since that solution is unlikely to occur, these individuals should not become candidates for donation after cardiac death without the consent of their durable power of attorney for health care or family.

Generally, organ procurement protocols require hospitals to inform their local organ procurement organization when they have identified a patient whose condition renders him or her a potential donor. The organ procurement organization usually wants its representatives to approach the family and seek their consent to organ donation. At Catholic Healthcare Partners we have written into our protocol for donation after cardiac death that pastoral care representatives will be involved in the consenting process. We have made this a requirement for two reasons.

Role of pastoral care

First, pastoral care staff have worked with the families of potential donors for some period of time before the issue of donation arises. They have developed a relationship with the family and frequently have been involved in assisting the family in grappling with the difficult decision to step down the level of aggressive care. In general, the families want pastoral care staff to support them when they are asked to make yet another difficult decision.

Second, pastoral care staff will continue to support family members as they move through the grieving process after the death of their loved one. Not infrequently, family members will question whether they made the right decision in authorizing the removal of life-supporting medical interventions. They may also question whether they made the right decision in authorizing organ donation after cardiac death.

Pastoral care staff can be effective in helping families make these very difficult decisions and resolving this sort of "second guessing" and lingering doubts. For precisely these reasons, some organ procurement organizations actually encourage the role of pastoral care in the consenting process.

Perfusing drugs

Some organ procurement organizations require the administration of drugs (heparin and/or phentolamine) into donors prior to their death in order to ensure that the organs remain perfused (Clark and Deshmunks, "Non-Heart Beating Organ Donation," *National Catholic Bioethics Quarterly*, Autumn 2004). It is important to note that these drugs are not intended to provide a medical benefit to the donor, but, rather, to maximize the likelihood that the organs being transplanted will remain viable for that purpose. The consent form for donation after cardiac death needs to make explicit reference to the administration and purpose of these drugs. That a physician should be compelled by a protocol to administer drugs that are not intended to benefit that patient appears to be a unique medical practice. The protocol in place within Catholic Healthcare Partners leaves to the discretion of each attending physician whether or not such drugs will be administered.

After the donor has been fully prepped and moved to an area adjacent to an operating room, and after the family has had an opportunity to say their final goodbyes, all life-supporting equipment is disconnected from the donor. To remain a viable donor, the patient must expire within a 60 to 90 minute window. If he/she does so, the transplant team steps in and the process of organ procurement begins. However, if the patient does not expire within the appropriate time frame, he or she is no longer deemed an appropriate candidate for organ donation. In this eventuality, the patient is returned to a hospital room until death occurs. The Catholic Healthcare Partners' protocol requires that an appropriate room is identified and prepared prior to the removal of life support, and that appropriate palliative care staff and pastoral care are prepared to step forward to provide care for the patient and family.

The ethical challenges presented by donation after cardiac death do not result from an inherently immoral process. The ethical challenges posed by this procedure are much more subtle. The key question is how to perform a procedure, to which the patient or his or her surrogate has consented, in a manner that continues to honor and respect the human dignity of a profoundly vulnerable member of our moral community.