

ORGAN DONATION AND PRUDENTIAL DELIBERATION

The Opinions of Physicians, Other Caregivers, and the Public at Large Should Be Taken into Consideration

BY JOHNNY COX, RN,
PhD, & CAROL
BAYLEY, PhD



Dr. Cox is vice president, theology and ethics, St. Joseph Health System, Orange, CA, and Dr. Bayley is director of justice and ethics education, Catholic Healthcare West, San Francisco.

Ethicists at St. Joseph's Health System, Orange, CA, and Catholic Healthcare West, San Francisco, have recently been responding to requests for protocols to retrieve organs for transplantation from non-heart-beating donors (NHBD). Organ procurement organizations are encouraging our hospitals to expand the pool of potential organ donors to include cadavers of persons whose death is determined by cardiopulmonary criteria. This expansion has inspired an ethical controversy, with powerful feelings on all sides.

The *Ethical and Religious Directives for Catholic Health Care Services* say, "Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue" (Directive 63).¹ If NHBD protocols were ethically and scientifically sound, Catholic hospitals would adopt them.

Essentially, the proposed protocols are aimed at procuring organs from trauma victims and others who, although gravely brain injured, may or may not reach the point of "brain death." After a decision has been made to cease artificial life support, the withdrawal of support is undertaken in a way that expedites organ recovery. This is known as a "controlled NHBD protocol" approach because the process is undertaken deliberately. Mechanical support is withdrawn, a fixed number of minutes are allowed to elapse, and if no spontaneous vital function returns within those minutes, the person is declared to have died and organs are procured.

Proponents of NHBD protocols emphasize that organ donation is a praiseworthy act of love and a source of consolation for most persons. They maintain that the current protocols for NHBD are scientifically sound and ethically safe-

guarded. Some opponents question NHBD protocols on scientific grounds regarding determination of death, while others focus on "the relative importance of the goals of saving lives through transplantation and respecting the dying during their last moments."²

Last spring the Division of Health Care Services of the Institute of Medicine (IOM) published *Non-Heart-Beating Organ Transplantation: Practice and Protocols*.³ This report addresses many of the more provocative ethical issues that have arisen since the University of Pittsburgh started promoting NHBD retrieval in the early 1990s. In fact, section five of the IOM report, "Protocol Development and Implementation," summarizes lessons learned from six programs that developed and approved protocols: "The approval process is complex, multileveled, and prolonged. The time each program spent from initiating the idea of non-heart-beating donation to full approval varied from eight months to three years."⁴

Because it takes time to develop solid protocols, we urge prudent caution in considering requests to approve them.

GATHERING THE COMMUNITY OF CONCERN

The richness of our Catholic health care heritage resides in our communities of healing. The Spirit's wisdom dwells in each and every one of us *gathered together*. We come together for decision making in which different sources of insight illuminate issues so that we might determine the most fitting thing to be done. The composition of the community of ethical reflection should reflect the complexity of the issue involved. Because the introduction of an NHBD protocol is both complex and controversial, the gathering of an appropriate community to consider it assumes central importance. Two groups seem

particularly significant: physicians who have scientific and medical expertise and community representatives who do not have vested interests in the outcome.

SCIENTIFIC CONSIDERATIONS

Debate continues about the specific criteria that suffice for death to be declared by irreversible cessation of circulatory and respiratory function. (A recent article in the *Hastings Center Report* pointed out many of these issues.⁵)

The details of this debate are not our concern here. Instead, we want to emphasize that appropriate introduction of an NHBD protocol requires that the hospital medical staff reach consensus on scientifically acceptable criteria. Reaching consensus will be a time-consuming but essential component of the protocol's development.

Directive 62 says, "The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria." Once a hospital's staff physicians have accepted a proposed protocol's scientific foundations, those proposing it can go on to evaluate other concerns. However, if the medical staff does not agree on appropriate criteria for declaring death, there is little point in addressing the other issues. It is vitally important to involve physician leaders (both formal and informal) and other staff physicians in developing and approving an NHBD protocol. We believe that successful implementation of any protocol is doomed without their support.

CONFLICTING INTERESTS AND COMPETING GOODS

Ethical decisions are difficult because they require one to choose among competing goods; saying yes to one good entails saying no to others. Organ retrieval and donation is fraught with competing goods, and caregivers who participate in it are at risk for conflict of interests. One way caregivers can guard against such conflicts is by establishing separate duties for the different persons involved. Directive 64 says, "In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team." This is a universal requirement in U.S. organ procurement practice.

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However, NHBD protocols introduce three additional risks of conflict.

Care versus Procurement

In recent years, many Catholic hospitals have made great strides in developing more routinized and reliable ways of caring for dying patients. More and more hospitals are attending to the physical setting of death, moving dying patients from an intensive care ward to a setting in

which family members or other loved ones can gather to keep vigil with them. In developing policies and practices for withholding or withdrawing life-sustaining treatment, such hospitals take care to respect the authority of surrogates, the person or persons selected to act in the best interest of the dying person. Some hospitals have developed comfort care pathways, in-patient hospice units, palliative care teams, and other specially structured ways of meeting the many needs of dying patients and their families.

In developing an NHBD protocol, a hospital must rigorously guard against anything that might undermine these efforts. By doing so, it will ensure that no conflict is set up between good care of the dying, on one hand, and the laudable goal of organ procurement, on the other. Such conflicts can be subtle. For example, a hospital that, for efficiency's sake, arranges for a patient's death to take place in a surgical suite, rather than in a hospice bed, risks elevating the goal of organ procurement above the goal of a peaceful, dignified death. A hospital may be trading away some intimacy if, in the interest of organ procurement, it allows strangers with monitors to attend a patient's death. A hospital that, in the interest of organ recovery, alters its CPR or pain management practices at the end of a patient's life may be treating that patient as a means more than as an end.

Staff Qualms We have noted that a hospital's physicians must agree on the scientific criteria for an NHBD protocol. The nurses and other staff members who will actually be with the patient through the process should also understand exactly what is happening.

Some nurses have said they experienced great stress when participating in NHBD protocols because they believed they were actually hasten-

ing death. Other nurses seriously object (as we do) to infusing a patient with heparin before death is declared, again for fear that death is being guaranteed to facilitate organ recovery. Some staff members have even worried that an NHBD patient might, if a spontaneous heartbeat occurred while the organ to be procured was still healthy enough to use, fail the protocol. Such caregivers fear that protocol failure would disappoint those family members who hope to find some meaning in the patient's death in the organ donation.

Hospitals should take these staff concerns seriously both in their development of an NHBD policy and in any education regarding it. If they do not, their interest in both advancing organ donation and delivering good patient care may conflict in a way that, for the nurse on the scene, may be difficult to resolve.

Public Fears Hospitals should also beware of a possible conflict between their efforts to expand the donor pool by using non-heart-beating donors, on one hand, and efforts to keep intact public confidence in the organ retrieval system so that the current pool can be maintained, on the other. Good candidates for organ procurement are sometimes lost because the general public does not understand elements of the current system.

"Brain death" is not universally recognized as death, for example. Although many health care workers, attorneys, and others know that "brain death" simply means death determined by neurological criteria (because mechanical life support has made it impossible to use cardiopulmonary ones), many lay people think of it as some lesser kind of death, a terrible not-quite-death. We reinforce this misunderstanding when we talk about removing "life" support (as opposed to mechanical ventilation) from a brain-dead patient.

Then, too, the members of some cultural groups, having excellent historical reasons for mistrusting the white American medical establishment, suspect that hospitals look for any excuse to cease treatment for certain patients. Any NHBD protocol that appears to a suspicious public to be more lax or less certain of death than current protocols will surely face resistance. Such protocols could also backfire and make a generally mistrustful public even less trusting.

For these reasons, Catholic hospitals ought to involve the lay community in the deliberation of new policies. A policy worthy of trust will always be developed in the light of scrutiny by intelligent and good-hearted neighbors. Suggesting that, because all hospital workers are potential patients, they can provide the necessary lay perspective in policy development is not enough. Genuine

scrutiny requires that underlying assumptions—about the importance of dying peacefully in one's own time, for example, or about the good of organ donation—be set out carefully before strangers, people unfamiliar with the hospital's culture. In this way, the potential for conflict between maintaining the current organ pool and expanding it using NHBD will be minimized.

PRUDENCE IS NECESSARY

Hospitals are communities of caring and centers of clinical excellence. Catholic hospitals strive to promote organ donation as a praiseworthy act of love. The introduction of NHBD protocols raises new scientific and ethical issues. Prudence requires deliberation and reflection. The authors of one article on the subject have put the case for judiciousness this way:

While patience is difficult when tens of thousands of people wait for organs, the recent history of organ procurement illustrates that the lack of process—of research, education, and dialogue—has its own consequences. Forging ahead based on assumptions not supported by data, failing to adequately educate and prepare the medical and lay communities, and failing to incorporate critical voices into the creation of policy and procedure make failure to address the organ shortage more likely.⁶

When an organ procurement organization requests consideration of an NHBD protocol, the executive teams and ethics committees involved should begin their work by assembling the appropriate community of reflection. Those teams and committees should initiate a process that ensures comprehensive consideration of these key issues by professionals and community representatives. □

NOTES

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Catholic Conference, Washington, DC, 1995.
2. Bethany Spielman and Steve Verhulst, "Non-Heart-Beating Cadaver Procurement and the Work of Ethics Committees," *Cambridge Quarterly of Healthcare Ethics*, no. 6, 1997, p. 282.
3. Institute of Medicine, *Non-Heart-Beating Organ Transplantation: Practice and Protocols*, National Academy Press, Washington, DC, 2000.
4. Institute of Medicine, p. 58.
5. S. J. Youngner, R. M. Arnold, and M. A. DeVita, "When is 'Dead'?" *Hastings Center Report*, November-December 1999, pp. 14-20.
6. Youngner, Arnold, and DeVita, p. 20.

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