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POLICY:

Patients or their surrogate decision makers (surrogates) have the right to accept or reject medical treatment, including the right to forego life-sustaining treatment. Patients and their surrogates in a designated order of priority also have the right to make anatomical gifts (gifts of the whole body or specified organs and tissues).

It is consistent with the mission of Beaumont Health System and ethically appropriate for patients and their surrogates to consider Organ Donation Following Cardiac Death (DCD), and for Beaumont Health System to support patients and their surrogates in making the choice whether to donate or not to donate organs and tissues.

This policy defines DCD as organ recovery from patients who are pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions. It is intended to provide surrogates with an additional option for donation, which complies with the patient's previously expressed wishes or the authorized surrogate's directives, as long as the surrogate's directives are not contrary to the patients previously expressed views. This option is offered to a surrogate ONLY AFTER the surrogate in conjunction with the medical staff has chosen to forego life-sustaining treatment.

The goals of this DCD policy are to:

a) Demonstrate respect for the wishes of patients and/or surrogates regarding organ donation.

b) Recover organs that can be transplanted, when consistent with the wishes of patients/surrogates, thereby meeting the needs of patients currently awaiting organ transplantation, and the needs of dying patients and their surrogates who may find satisfaction in making a gift of life.

c) Maintain the integrity and quality of organ and tissue recovery through DCD.

d) Support surrogates/families of patients in the decision making process and in the organ and tissue recovery process through DCD.

e) Support Beaumont Health System's staff participating in organ and tissue recovery through DCD.

GENERAL:

Appropriate candidates for DCD are limited to those patients who meet the following criteria:

- The patient has a non-recoverable illness or injury that has caused neurological devastation and/or other body system failure resulting in ventilator dependency.

- The patient/appropriate surrogate decision maker, in conjunction with the medical staff, has decided to withdraw life-sustaining treatment.

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GENERAL: (Cont'd)

- In the opinion of the health care team, cardiopulmonary death will likely occur within ninety (90) minutes following withdrawal of life-sustaining treatment.

- The patient's level of central nervous system (CNS) incapacitation is not due to the influence of CNS depressant drugs, metabolic coma or body temperature <32.2C.

The decision to remove life support is separate and distinct from and must be made prior to and independently of the decision to donate organ(s) and/or tissue(s).

If the patient is not competent to consent to the removal of life support, the appropriate surrogate decision maker for the purpose of consenting to the removal of life support is a court appointed guardian, patient advocate acting under a Durable Power of Attorney for Health Care or family member, in the order of priority and as described in Policy #307 "Guidelines for Withdrawing or Withholding Life Sustaining Treatment".

This policy should in no way undermine or impede the process of declaring appropriate patients dead by reason of irreversible cessation of spontaneous brain function, in accordance with Policy #317 "Determination of Death by Neurological Criteria (Brain Death)."

The well being of the patient will remain the primary responsibility of the attending physician and the health care team. The comfort and needs of the patient will be continually evaluated and addressed.

Appropriate decision makers for purposes of DCD are an adult patient of sound mind, or the following surrogates in the following order of priority: patient advocate with authority stated in the patient advocate designation to the extent of the stated authority, spouse, adult child, either parent, adult sibling, guardian of the person of the patient, or other individual with authority to dispose of the patient's body. A surrogate in a lower priority may make a donation if a person in a higher priority is not available or not capable. Such a surrogate may make a donation only if the surrogate has no knowledge of the patient's unwillingness to donate or of the unwillingness of any person in the same or a higher priority. A donation made by a surrogate in a higher priority is not revocable by a person in a lower priority.

PROCEDURE:

Gift of Life of Michigan (Gift of Life) will be notified by the Bereavement Representative or designee of all imminent deaths as provided in Policy #311, "Anatomical Gifts."

The Gift of Life Coordinator will consult with the health care team to determine the suitability of the patient for DCD. No tests or procedures will be performed on the patient without approval of the attending physician and/or intensivist, who will approve only those tests or procedures ordinarily undertaken for the patient's comfort or to treat the patient's underlying disease. No tests or procedures that ordinarily require consent of a patient or surrogate will be performed without the consent of the patient or surrogate.

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PROCEDURE: (Cont'd)
If the patient's condition does allow for DCD, the Gift of Life Coordinator, with the knowledge of the attending physician and/or intensivist, will work with the health care team to develop an appropriate plan to discuss the option of DCD with the surrogate.

A hospital chaplain and/or designee will be on-site to support the surrogate/family and serve as an advocate for the surrogate/family in the process of informed consent. A Gift of Life Family Support Person may be asked to assist by the chaplain and/or designee in this support.

If the patient's condition does not allow for DCD or if the patient/surrogate does not consent to DCD, withdrawal of life-sustaining treatment and care of the patient will be conducted in accordance with Policy #307 "Guidelines for Withdrawing or Withholding Life Sustaining Treatment."

It is the responsibility of the Bereavement Representative (Royal Oak) and Nurse Manager/Administrative Representative (Troy & Grosse Pointe), in conjunction with the Gift of Life Coordinator, to contact the Medical Examiner (ME) in cases that are within the jurisdiction of the ME. Any restrictions of donation by the ME will be discussed with the surrogate/family at this time.

Any ethical issue or concern raised by any staff member, surrogate or family member will be addressed in accordance with Policy #309, "Clinical Ethics," If the ethical issues and/or concerns are justified, or the surrogate with priority does not consent following consultation or withdraws consent previously given, DCD will not proceed.

If the ethical concerns are related to the staff member's personal beliefs regarding DCD, the staff member may choose to not participate in the process based on Human Resource Policy #268, "Staff Deference."

CONSENT FOR DCD

The surrogate will be approached about the possibility of DCD ONLY AFTER a decision to withdraw life-sustaining treatment has been agreed to by the patient/appropriate surrogate decision maker and the attending physician. The decision about withdrawal of treatment and the decision about DCD must be made independently of one another.

The Gift of Life Coordinator will approach the surrogate/family of patients who meet the criteria for DCD. A member of the health care team will be present and serve as the advocate for the patient and surrogate/family. The Gift of Life of Michigan Coordinator will provide:

- An explanation of DCD and the opportunity for donation.
- An explanation of the medical and ethical rationale for DCD.
- A clear statement that the surrogate is free to agree to or refuse donation.
- An explanation of where and how support will be withdrawn and of the measures used to maintain patient comfort

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CONSENT FOR DCD (Cont'd)

- A period of time for questions about the donor process.
- A period of time for the surrogate to consider the decision.
- An explanation of any additional procedures needed for DCD, including premortem procedures that may not be for the benefit of the patient (e.g., use of drugs, cannulation, bronchoscopy, liver biopsy, and other similar procedures), and their risks and complications and measures used to maintain patient comfort.
- Documentation of the surrogate's decision.

If the surrogate consents to DCD, the routine consent forms and process of donor evaluation will be followed by the Gift of Life Coordinator, in accordance with Procedure #311-1, "Anatomical Gift Requests."

A plan for the withdrawal of life sustaining treatment will be discussed with the surrogate and family during the consent process. The attending physician or designee and Gift of Life Coordinator will explain the procedures for withdrawal of treatment and answer any questions of the surrogate and family. The plan for withdrawal should keep three primary goals in mind: 1) the patient's comfort, 2) the ability to successfully recover organs for transplantation, and 3) meeting the needs of the surrogate and family to grieve and spend appropriate time with the patient. The health care team will support this process through flexible visiting by the surrogate and family with the patient. The chaplain will play a key role in this process by advocating for and serving the needs of the surrogate and family. The Chaplain and/or designee may request assistance from a Gift of Life Family Support Person.

If the patient should sustain cardiac arrest before the decision to withdraw life-sustaining treatment has been made by the attending physician and surrogate and documented, any pre-existing orders as to CPR control will be followed.

If the patient should sustain cardiac arrest after the decision to withdraw life-sustaining treatment has been made by the attending physician and patient/appropriate surrogate decision maker and documented, but before the process of informed consent concerning DCD has been completed, the patient will not undergo CPR. Comfort measures and ventilatory support, if any, will be continued until further decisions are made.

PATIENT MANAGEMENT AFTER CONSENT

To facilitate organ recovery, the patient must be maintained on a ventilator and hemodynamically supported for organ perfusion until withdrawal of ventilatory support. The Gift of Life Coordinator will work in conjunction with the hospital medical staff to request medical consultations and laboratory studies to determine the suitability of the organs for transplantation.

Comfort measures will be provided during any testing period and during withdrawal of life support, in accordance with applicable standards of practice for the care of persons undergoing the same or similar types of procedures who are not candidates for DCD. Palliative care will remain the primary goal of

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PATIENT MANAGEMENT AFTER CONSENT (Cont'd)
patient care during this period. Families should be permitted to consent to, or refuse to consent to, the use of measures to restore circulation and oxygenation to the organs of a candidate for DCD if cardiovascular arrest occurs during testing. Surrogate/family support will continue during this period

Results from studies related to the suitability of organs for transplantation will be expedited as soon as possible. The surrogate/family will be informed of the approximate wait for these studies to be completed.

If the studies reveal that the patient cannot serve as an organ donor, the surrogate/family will be informed. They will also be informed of the continued option for tissue donation. The chaplain and/or designee will provide support during this reporting phase. The surrogate may refuse to continue with tissue donation at this point. The surrogate's right to refuse will be explained and any decision to refuse will be supported.

If the studies confirm the patient's suitability as an organ donor, the surrogate/family will be informed. The Gift of Life Coordinator will review the plan agreed to earlier regarding withdrawal of life-sustaining treatment and DCD.

WITHDRAWAL OF LIFE SUSTAINING TREATMENT AND PRONOUNCEMENT OF DEATH

The patient and surrogate/family will be transferred to the designated area (preop/PACU/OR) with the patient being mechanically ventilated and monitored by the critical care team.

When the transplant team has been assembled (See: Organ Retrieval Procedure), and has performed any procedures preparatory to transplantation as explained in the consent process (See: Consent for DCD), the transplant team will withdraw from the area where the patient is being treated, and will have no role in the continuing care of the patient. The critical care team will be responsible for withdrawal of mechanical ventilation in accordance with the procedures in Policy #307, "Guidelines for Withdrawing or Withholding Life Sustaining Treatment," and will be responsible for all medical care of the patient until the patient is pronounced dead.

Death will be pronounced by the attending physician or his/her physician designee. The physician certifying death will not be involved as a part of the organ/tissue transplant or recovery team. No steps will be taken to intentionally hasten the death of the patient.

The Bed Coordinator – Royal Oak & Troy, Admitting – Grosse Pointe will assign and hold the patient's critical care bed for the patient in the event the patient does not expire within ninety (90) minutes after termination of support (See: Care When DCD is Not Successful).

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ORGAN RETRIEVAL PROCEDURE

After suitability has been determined and consent obtained, the Gift of Life Coordinator will assemble a transplant team and inform the Operating Room staff. The transplant team will arrive at the hospital and follow procedures in accordance with the organ donation protocol.
Criteria for declaring death prior to donation of organs after cardiac death are as follows: Death may only be declared after a five (5) minute waiting period following the cessation of circulation [defined as the absence of sufficient cardiac activity to generate a pulse or blood flow (not necessarily the absence of all electrocardiographic activity)], during which time the patient must have no respiratory effort (apneic) and be completely unresponsive. It is highly recommended that cessation of circulation be documented with absent blood pressure via an arterial pressure catheter. If the placement of an arterial catheter is not feasible, a zero blood pressure should be documented in addition to absent pulses in the femoral, carotid or brachial arteries by Doppler. An attending physician must certify in writing that these criteria were met for a full five (5) minutes before declaration of death; upon such declaration of death, surgical recovery of organs may commence.

After surgical recovery of organs, the surrogate/family may wish to view the body of the deceased. The surrogate/family should be allowed to view the body prior to transfer to the morgue. This viewing will take place in the isolation room in PACU on the second floor, North Tower (Royal Oak), in ENDO, Room 9 (Troy), or the Critical Care Unit (Grosse Pointe). Hospital staff should support this request in a sensitive manner and as similar requests are handled in relation to other deaths in the Operating Room area.

Release of the body to a funeral home or Medical Examiner will take place in a manner consistent with Policy #495 "Expiration of a Patient"

CARE WHEN DCD IS NOT SUCCESSFUL

A discussion with the patient's family members about possible contingencies in the O.R. must be conducted before the patient's transfer to the O.R. This discussion must include the time frame allowed for the patient to expire after withdrawal of life sustaining treatment. This time frame is based on a determination of predicted organ viability after life sustaining treatment is withdrawn and in no case will this time frame exceed ninety (90) minutes. When organ donation is not possible, the attending physician will be notified to provide continuing medical care for the patient, and the patient will be returned to the unit from which the patient was transferred to the O.R.

The critical care unit receiving the patient will be informed by the Bed Coordinator – Royal Oak and Troy and Admitting – Grosse Pointe. The staff from that unit will be prepared to continue palliative care for the patient and support of the surrogate/family. The attending physician may transfer the patient to a non-critical care bed, consistent with the patient's medical needs and bed availability.

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CARE WHEN DCD IS NOT SUCCESSFUL (Cont'd)
The Gift of Life Coordinator and the chaplain and/or designee will inform the surrogate/family in person, or at a previously agreed upon telephone number, if the surrogate/family has chosen to leave the hospital.

The chaplain or designee will continue to provide support for the patient and surrogate/family during the continuing care of the patient.

CARE OF THE SURROGATE/FAMILY

Care of the surrogate/family is a primary responsibility of Beaumont Health System's health care team, including a hospital chaplain. The chaplain will serve in the role of primary patient/surrogate/family advocate, and will support the surrogate/family through the process of informed consent for DCD, encourage communication and provide spiritual and emotional care.

Additional support may be provided through access to the surrogate's/family's' own clergy person(s), which is welcomed and encouraged. The chaplain or designee will facilitate contact with the surrogate's/family's own clergy person(s), and may request assistance from a Gift of Life Family Support Person.

The chaplain and/or designee will provide reports from surgery for those who consent to DCD. In the event that DCD is not successful and the patient is moved back to a nursing unit bed, the chaplain and/or designee will provide support for the family/surrogate throughout the dying process.

CARE OF BEAUMONT HEALTH SYSTEM'S STAFF

DCD requires that all staff involved receive adequate training in the protocol and unique medical aspects of DCD. Training will be the responsibility of the Organ and Tissue Donation Committee (Royal Oak), Department of Education (Troy & Grosse Pointe) and Gift of Life of Michigan working in conjunction with the nursing/surgical unit directors and medical staff involved.

DCD may present some staff members with a conflict of conscience. Staff must be allowed to forego participation in DCD in a manner consistent with Policy #302, "Staff Deference."

DCD may cause emotional distress for staff. Opportunity for debriefing and discussion will be offered following each case of DCD. Spiritual Care Services (Royal Oak & Grosse Pointe) and Pastoral Care (Troy) will be responsible for providing this opportunity within 72 hours of the completion of any donation or attempted donation through DCD.

Reports of staff response to DCD will be made to the Chair of the Organ and Tissue Donation Committee.

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BEAUMONT HEALTH SYSTEM'S QUALITY REVIEW OF ORGAN AND TISSUE RECOVERY THROUGH DCD

Review of cases will include the following:

- Interviews with ICU staff, attending physician or his/her designee, OR staff, chaplain, and Gift of Life Coordinator. The focus of the interview will be on overall satisfaction with the process, as well as inquiring into any improvements that might be made. The Chair of the Organ and Tissue Donation Committee or his/her designee is responsible for these interviews.
- A follow-up phone call to the surrogate/family will be made within eight weeks by the chaplain or designee who was the surrogate's/family's advocate during the decision-making and/or donation process. This call will focus on overall satisfaction with care of the patient and surrogate/family.
- The DCD Nurse coordinator will present the rate of successful transplantation of organs recovered through DCD at the Organ and Tissue Donation Committee.
- A brief summary of each organ donation case will be presented to the Institutional Ethics Committee (IEC) at its monthly meetings by the Organ Donation Coordinator. The information presented will include feedback from interviews with ICU staff, the attending physician, spiritual care, other staff, immediate family members, and the Gift of Life Coordinator.

RELATED POLICIES

Policy 495 - Expiration of a Patient
Policy 268 - Staff Deference
Policy 307 - Guidelines for Withdrawing or Withholding Life Sustaining Treatment
Policy 308 - End of Life Care
Policy 309 - Clinical Ethics
Policy 311 - Anatomical Gifts
Policy 317 - Determination of Death by Neurological Criteria (Brain Death)

[1] Steinbrook R. Organ donation after cardiac death. *N Engl J Med* 2007; 357 (3): 210