

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 10 - A-05

Subject: Organ Procurement Following Cardiac Death, *Amendment*

Presented by: Michael S. Goldrich, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Art L. Klawitter, MD, Chair)

1 After reviewing Opinion E-2.157, “Organ Procurement Following Cardiac Death,” (AMA Policy
2 Database) the Council on Ethical and Judicial Affairs (CEJA) has determined that several sections
3 of the policy are outdated and need to be amended. The proposed changes below aim to bring the
4 policy up-to-date by (i) introducing more contemporary terminology; (ii) acknowledging the
5 different circumstances – controlled and uncontrolled – under which donation after cardiac death
6 might arise; (iii) removing the specific reference to how much time should elapse between cardiac
7 arrest and the pronouncement of death, and (iv) eliminating language that calls for further pilot
8 programs of organ removal following withdrawal of life-sustaining treatment.

9
10 Generally, edits of a current Opinion that simply provide clarification and do not change the
11 substance of guidelines are presented to the House of Delegates in the form of a CEJA Opinion,
12 which is then filed. Because the proposed amendments to current Opinion E-2.157 introduce
13 substantive changes, CEJA presents the edited Opinion to the House of Delegates in the form of a
14 Report, to foster discussion of these changes before it issues the amended Opinion.

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16 RECOMMENDATIONS

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18 The Council recommends that Opinion E-2.157, “Organ Procurement Following Cardiac Death,”
19 be amended as follows and the remainder of the Report be filed.

20
21 E-2.157 Organ Donation After Procurement Following Cardiac Death.

22
23 Given the increasing need for donor organs, protocols for procurement following donation
24 after cardiac death (DCD) have been developed. ~~In some instances, Controlled DCD~~
25 allows patients who have agreed to be taken off of life support or their surrogate decision
26 makers the opportunity to donate the patients’ organs once death has been declared request
27 ~~withdrawal of life support and choose to serve as organ donors.~~ In these cases, the organs
28 can be preserved best by discontinuation of life support is discontinued in or near the

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1 operating room so that organs can be removed ~~two minutes following cardiac~~
2 ~~death~~ promptly after death is pronounced. ~~In other scenarios, patients~~ DCD also may be
3 considered from patients who suffer unexpected cardiac death (uncontrolled DCD). It
4 requires that they may be cannulated and perfused with cold preserving-preservation fluid
5 (in situ preservation) within minutes after death to maintain the viability of organs. Both of
6 these methods may be ethically permissible, with attention to certain safeguards.

7
8 (1) Hospital policies should specify important details of the DCD process, such as the
9 required time delay before death can be pronounced after cardiac arrest.

10
11 ~~(2)~~ In controlled DCD, the decision to withdraw life support should be made by the
12 patient or the patient's surrogate decision maker before any mention of organ donation
13 (unless the patient or surrogate spontaneously broaches the subject). ~~When securing~~
14 consent for life support withdrawal and organ retrieval, the health care team must be
15 certain that consent is voluntary. This is particularly true where surrogate decisions
16 about life-sustaining treatment may be ~~This is meant to ensure that withdrawal of life~~
17 support is not influenced by the prospect of organ donation. ~~If there is any reason to~~
18 suspect undue influence, a full ethics consultation should be required.

19
20 The informed consent for controlled DCD should include specific discussion of pre-
21 mortem interventions aimed at organ preservation, to improve the opportunity for
22 successful transplantation, rather than to benefit the patient. Interventions that are
23 likely to hasten death must not be used.

24
25 ~~(23)~~ In all instances, it is critical that there be no to avoid perceived or actual conflicts of
26 interest in the health care team with respect to caring for the patient versus facilitating
27 organ donation. ~~These~~ The health care professionals providing care at the end of life
28 must ~~should~~ be separated distinct from providers those participating in on the
29 transplant team. ~~No member of the transplant team may have any role in the decision~~
30 to withdraw life support or in the process leading to pronouncement of death.

31
32 ~~(3)~~ Further pilot programs should assess the success and acceptability of organ removal
33 following withdrawal of life-sustaining treatment.

34
35 (4) Palliative care for DCD candidates should continue after removal of life support until
36 death is declared.

37
38 ~~(45)~~ In cases of uncontrolled DCD ~~in situ~~ preservation of cadaveric organs, the prior
39 consent of the decedent to organ donation or the consent of the decedent's surrogate
40 decision maker ~~makes perfusion is~~ ethically permissible ~~required~~. Perfusion without
41 either consent to organ donation prior specific consent to perfusion or general consent
42 to organ donation violates requirements for of informed consent for medical
43 procedures and ~~should is~~ not be permitted ~~permissible~~.

44
45 ~~(5)~~ The recipients of such procured organs should be informed of the source of the organs
46 as well as any potential defects in the quality of the organs, so that they may decide
47 with their physicians whether to accept the organs or wait for more suitable ones.

48
49 ~~(6)~~ Clear clinical criteria should be developed in place to ensure that only appropriate
50 candidates, whose organs are reasonably likely to be suitable for transplantation, are
51 considered eligible to donate organs under these protocols. (I, III, V) (Modify
52 HOD/CEJA Policy)

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Issued June 1996 based on the reports “Ethical Issues in the Procurement of Organs Following Cardiac Death: The Pittsburgh Protocol” and “Ethical Issues in Organ Procurement Following Cardiac Death: In Situ Preservation of Cadaveric Organs,” adopted December 1994; updated June 2005.

APPENDIX

The amended Opinion would read as follows:

E-2.157 Organ Donation After Cardiac Death.

Given the increasing need for donor organs, protocols for donation after cardiac death (DCD) have been developed. Controlled DCD allows patients who have agreed to be taken off of life support or their surrogate decision makers the opportunity to donate the patients' organs once death has been declared. In these cases, life support is discontinued in or near the operating room so that organs can be removed promptly after death is pronounced. DCD also may be considered from patients who suffer unexpected cardiac death (uncontrolled DCD). It requires that they be cannulated and perfused with cold preservation fluid (*in situ* preservation) within minutes after death to maintain the viability of organs. Both of these methods may be ethically permissible, with attention to certain safeguards.

- (1) Hospital policies should specify important details of the DCD process, such as the required time delay before death can be pronounced after cardiac arrest.
- (2) In controlled DCD, the decision to withdraw life support should be made by the patient or the patient's surrogate decision maker before any mention of organ donation (unless the patient or surrogate spontaneously broaches the subject). This is meant to ensure that withdrawal of life support is not influenced by the prospect of organ donation.

The informed consent for controlled DCD should include specific discussion of pre-mortem interventions aimed at organ preservation, to improve the opportunity for successful transplantation, rather than to benefit the patient. Interventions that are likely to hasten death must not be used.

- (3) In all instances, it is critical to avoid perceived or actual conflicts of interest in the health care team with respect to caring for the patient versus facilitating organ donation. The health care professionals providing care at the end of life should be distinct from those participating on the transplant team. No member of the transplant team may have any role in the decision to withdraw life support or in the process leading to pronouncement of death.
- (4) Palliative care for DCD candidates should continue after removal of life support until death is declared.
- (5) In cases of uncontrolled DCD, prior consent of the decedent to organ donation or consent of the decedent's surrogate decision maker is ethically required. Perfusion without consent to organ donation violates requirements of informed consent for medical procedures and is not permissible.
- (6) Clear clinical criteria should be in place to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under these protocols. (I, III, V)

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