

Exploring the dilemma of hospital refusal to perform controlled organ donation after circulatory death (DCD)

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Abstract

Organ donation following circulatory death (DCD) or brain death (BD) facilitates life-saving transplantation for thousands of patients worldwide each year. Both DCD and BD protocols require that the donor be declared dead before organ procurement. Some hospitals refuse to perform DCD donations based on moral and other objections, and this creates a complex dilemma for families attempting to honor the donation wishes of their relatives. Because organ donation is a community good, any accommodation of staff objection that impedes or harmfully delays DCD donation is ethically impermissible. Furthermore, hospital refusal to perform DCD donation is ethically untenable.

Key words: organ donation, transplant, refusal to participate, conscience.

Conscientious objection

The concept of a healthcare worker refusing to perform a specific healthcare activity due to conscientious objection is well-documented in medical literature. The refusal and accommodation is generally observed in the areas of sterilization, contraception, and abortion with the provision that no patient be abandoned in the situation of an emergency [8]. The concept of conscientious objection becomes more complex, however, when organizations as a whole, refuse to provide a *community* service. Specifically, when an individual objects to performing a service, another individual steps in and provides it. When a patient is admitted to a hospital and the hospital, as an entity, refuses to provide a service that is a common practice that benefits society and does not require specialized skills or equipment, a dilemma results.

Introduction

World-wide, the need for donor organs far outweighs the supply. In the United States (US) there were over 120 000 patients awaiting transplant as of November 10, 2015 [1]. Various strategies are used to help encourage donations such as community education and Internet registries, while transplant technology has also evolved to include living donation, split liver transplants [2], re-use of donor organs [3], and ex-vivo perfusion to optimize graft performance [4, 5]. The premise of deceased organ donation is that the organ donor must be declared dead prior to graft procurement. Declaration of death is required for procurements involving brain death (BD) as well as circulatory death.

BD is the “irreversible and permanent cessation of all brain function” [6]. Grafts procured in the setting of controlled circulatory death involve firstly, the determination that further treatment of the patient is futile, and secondly, the decision to withdraw artificial life support (e.g., dialysis, feeding tube, ventilator). After the decision to withdraw life support has been made, the possibility of organ donation can be considered, but organ procurement can only occur *after* the patient has died. Donation under these circumstances is considered controlled donation after circulatory death (DCD) [6]. In the US, DCD is a legal procedure; however, a large healthcare system (Dignity Health) refuses to allow this type of organ donation at their hospitals [7]. This paper explores their objection and the resulting dilemma for families who wish to pursue DCD.

Why does Dignity Health forbid DCD?

Dignity Health is the fifth largest healthcare system in the US, comprising 22 Catholic and 17 secular hospitals. They do not cite a religious objection to DCD but rather, they argue that DCD potentially “violates the dead donor rule” [7]. The dead donor rule is the informal term used to describe the requirement that donors be dead before organ procurement. Empirical evidence indicates that after five minutes, spontaneous return of circulation will not occur [9] and patients are permanently dead (and irreversibly dead without interventions). Yet while five minutes is a clinically and ethically suitable wait time [10], DCD protocols have various “no touch” timeframes and a longer wait time means that hospitals desire a larger comfort zone before beginning procurement rather than not allowing DCD.

Dignity Health also argues that DCD causes concern about the hospital’s “efforts in palliative care and the pursuit of a peaceful death for their dying patients” [7]. Specifically, they report a DCD case in the early history of Dignity Health which involved discontinuing a patient’s seizure medication as part of withdrawal of life support, resulting in visible seizures until asystole [7]. This was harmful for the patient and the clinical staff and resulted in a moratorium on future DCDs. The case described was both tragic and unfortunate because palliative care is intricately linked to the prac-

tice of withdrawal of life support and comfort care, thus the palliative medicine team should be actively involved in the patient's care. In all DCD cases, the patient's welfare is always the first priority and thus discontinuing seizure medication was clinically and ethically inappropriate. There is nothing in DCD protocols that shields or excludes palliative medicine or pastoral care from patients when they are dying and in fact, DCD protocols reinforce their provision [11]. Additionally, *pre-mortem* interventions that optimize organ donation (e.g., heparin, vasodilators, bronchoscopy, cannula placement) are ethically permissible with patient or family consent as long as the risk for patient harm is low (and there are no jurisdictional legal prohibitions) [12].

Dignity Health also has economic concerns about DCD. Specifically, they worry about the resources spent on DCD [7]. The use of palliative care and pastoral care during the DCD process should be viewed as a standard cost of doing business as a hospital (duty of care) because both palliative care and pastoral care would be offered and provided to dying patients regardless if they were destined to be organ donors. Furthermore, palliative care and pastoral care would also be standard services for non-dying patients, for example, those with intractable symptoms [13]. The additional costs associated with *pre-mortem* donation interventions are minimal when compared to the significant costs saved with the implementation of transplantation when kidney recipients no longer need dialysis [14]. Additionally, aside from the use of non-palliative clinicians to perform *pre-mortem* activities, personnel resources are identical for DCD and non-DCD cases because in both settings of withdrawal of support, the palliative care team manages the patient during the dying process.

A final concern of Dignity Health is lack of assurance that any DCD policy would be properly adhered to by hospital staff and organ procurement organizations [7]. This concern seems overly broad as oversight mechanisms for organ donation already exist, internally and externally. Hospitals often have organ donation committees which meet monthly to review cases [15]. Hospitals can also conduct their own internal audits and implement corrective action when deficiencies are identified. In the US, the United Network for Organ Sharing [16] and its partner, Organ Procurement and Transplantation Network [17], monitor the activities of transplant programs and organ procurement organizations through on-site audits.

Overall, while Dignity Health's objection to DCD is not based on theological or Catholic tenets, their list of objections creates [organizational] moral distress. The resultant moral distress can be argued to be the root of their conscientious objection.

Organ donation as a community good

In general, hospitals choose what services they will provide to their community, and their choices are based on many things including economics [18, 19] and organizational philosophy. In fact, in the US there is no Federal law that requires hospitals to have an Emergency Department [19] but certainly hospitals should consider their geographic location and the clinical needs of the community they serve.

Organ donation is a community good [20] because it facilitates transplantation, a clinically proven life-saving technology for children and adults. And while it is generally accepted that it is unethical to require people to donate their organs upon death, the *opportunity* to be an organ donor should be made available to everyone. Opportunities for organ donation are made available when hospitals implement organ donation protocols and allow organ procurement organizations access to their facility for case assessment, family counselling, and organ retrieval. In fact, the *Ethical and Religious Directives for Catholic Health Care Services* [21] state, "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, for ethically legitimate purposes, so that they may be used for donation and research after death."

The limits of conscientious objection

Consider the anonymized ethics consultation involving an adult with devastating injuries following a vehicle accident. After over two weeks of intensive care treatment relatives made the decision to withdraw life support due to the futility of continued interventions. The family supported the patient's desire for organ donation yet the hospital refused to permit DCD at their facility. The family, who had bonded with the medical team, was forced to transfer their relative to another hospital via ambulance and begin a relationship with a new clinical team. Withdrawal of life support and organ donation occurred at this "foreign" site with transfer-related emotional trauma to the family. A similar case of distressing ambulance transfer was chronicled in a video by the widow of her organ donor husband [15].

When conscientious objection delays, impedes, or blocks clinical community good, it is ethically impermissible. In the setting of DCD, *individual* healthcare workers who have a moral objection can be given an accommodation (allowed to opt-out of participating) as long as there is another practitioner to provide the needed clinical activity without delay so that procurement efforts are not harmed [22]. Within a jurisdiction where DCD is legal, hospitals, as an organization, cannot be afforded accommodation to object to DCD be-

cause for inpatients, their organization's objection will delay, impede and potentially block organ donation. In the case of Dignity Health, their refusal to perform DCD violates their own ethical directive [21]. If they desire to block other services which are not community goods (e.g., medical or surgical contraception), such could potentially be ethically permissible if other means of access was available without excessive burdens (e.g., distance, cost).

Some might argue that reasonable accommodation could be made by transferring dying patients from non-DCD hospitals to hospitals that perform DCD. This option is ethically untenable on several grounds: 1) transfer creates an unnecessary financial burden due to the cost of ambulance transfer of a patient on life support; 2) transfer creates emotional strain on families due to the severing of existing relationships and the need to create new ones at the receiving facility; 3) transfer delays DCD and this potentially clinically harms patients on the transplant waiting list as they further suffer/deteriorate/die while waiting for donation; 4) insurance restrictions might force some patients to remain in a non-DCD facility or face lack of insurance benefits/reduced benefits with transfer elsewhere. A hospital's value system should not be forced on those who lack autonomous choice.

Conclusion

In the US, Federal regulations [23] require hospitals to report all deaths (any type) and all impending deaths to the regional organ procurement organization to give every patient the opportunity to be an organ donor (whether or not they are registered). If a patient or family desires organ donation and the death is DCD, the reporting hospital should facilitate the donation. Because organ donation is a community good, any accommodation of staff objection that impedes or harmfully delays DCD donation is ethically impermissible. Furthermore, hospital refusal to perform DCD donation is ethically untenable due to financial, emotional, and clinical harms.

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Zusammenfassung

Die Organspende nach Herz-Kreislauf-Stillstand (DCD) oder nach Hirntod (BD) ermöglicht weltweit jedes Jahr tausenden von Patienten eine lebensrettende Transplantation. Sowohl die DCD- als auch die BD-Protokolle setzen voraus, dass vor der Organentnahme der Tod des Spenders festgestellt wurde. Es gibt einzelne Spitäler, die sich aufgrund moralischer und anderer Einwände weigern, DCD durchzuführen. Dies führt dazu, dass Familien, die dem Wunsch ihres Angehörigen nachkommen möchten, seine Organe zu spenden, vor einem Dilemma stehen. Da jede Organspende auch im öffentlichen Interesse liegt, ist die Weigerung des Gesundheitspersonals, die dazu führt, dass die Durchführung einer DCD verzögert wird, ethisch unzulässig. Es ist auch ethisch nicht haltbar, wenn Spitäler sich weigern, DCD durchzuführen.

Résumé

Il est prouvé que le don d'organe, après un arrêt circulatoire ou une mort cérébrale, peut sauver des milliers de vies chaque année à travers le monde. Il doit évidemment être confirmé que le donneur est mort, soit par arrêt circulatoire soit par mort cérébrale, avant tout prélèvement d'organe. Certains hôpitaux refusent d'accepter le don d'organe à la suite d'un arrêt circulatoire, fondant cette décision sur des objections entre autres morales. Ceci confronte donc les familles à un dilemme lorsqu'elles souhaitent honorer le souhait de don d'organe voulu par leur proche décédé. Le don d'organe représentant un bien commun, utile à la communauté, toute contestation du personnel soignant qui entrave ou retarde excessivement un don d'organe après un arrêt circulatoire est éthiquement inadmissible. Ainsi, le refus des hôpitaux de procéder au prélèvement d'organe après un arrêt circulatoire est éthiquement inacceptable.

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References

1. www.unos.org (accessed 10.11.2015).
2. Lauterio A, Di Sandro S, Concone G, De Carlis R, Giacomoni A, De Carlis L. Current status and perspectives in split liver transplantation. *World J Gastroenterol.* 2015;21(39):11003–15.
3. Ringers J, Dubbeld J, Baranski AG, et al. Reuse of auxiliary liver grafts in second recipients with chronic liver disease. *Am J Transplant.* 2007;7(11):2615–8.
4. Weeder PD, van Rijn R, Porte RJ. Machine perfusion in liver transplantation as a tool to prevent non-anastomotic biliary strictures: Rationale, current evidence and future directions. *J Hepatol.* 2015;63(1):265–75.
5. Guarrera JV, Henry SD, Samstein B, et al. Hypothermic machine preservation facilitates successful transplantation of “orphan” extended criteria donor livers. *Am J Transplant.* 2015;15(1):161–9.
6. United Network for Organ Sharing. Talking About Transplantation: What Every Patient Needs to Know. 2013.
7. Bayley C, Kurtz M, Soper B. Hospitals grapple with the ethics of donation after cardiocirculatory death. *Med Ethics Advisor* 2012; May: no page numbers.
8. American Congress of Obstetricians and Gynecologists Committee on Ethics. ACOG Committee Opinion# 385: The Limits of Conscientious Refusal in Reproductive Medicine. 2013.
9. Manara AR, Murphy PG, O’Callaghan G. Donation after circulatory death. *Br J Anaesth.* 2012;108 Suppl 1:i108–21.
10. American College of Critical Care Medicine, Society of Critical Care Medicine Ethics Committee. Recommendations for non heart beating organ donation [position paper]. *Crit Care Med* 2001;29: 1826–31.
11. Catholic Health Association of the United States. Sample Policy 1: Donation After Cardiac Death. *Health Care Ethics USA* 2007;15: 12–15.
12. Gries CJ, White DB, Truog RD, et al. An official American Thoracic Society/International Society for Heart and Lung Transplantation/Society of Critical Care Medicine/Association of Organ and Procurement Organizations/United Network of Organ Sharing Statement: ethical and policy considerations in organ donation after circulatory determination of death. *Am J Respir Crit Care Med.* 2013; 188(1):103–9.
13. Edmonds P, Hart S, Wei Gao, Vivat B, Burman R, Silber E, Higginson IJ. Palliative care for people severely affected by multiple sclerosis: evaluation of a novel palliative care service. *Mult Scler.* 2010; 16(5):627–36.
14. www.kidney.org.uk/archives/news-archive-2/campaigns-transplantation-trans-cost-effect (accessed 11.11.2015).
15. UC Irvine News. Giving the Gift of Life: UC Irvine Medical Center Celebrates Organ Donors & Families. 15.12.2009. www.youtube.com/watch?v=FddDgnQoisA (accessed 12.11.2015).
16. www.unos.org (accessed 11.11.2015).
17. https://optn.transplant.hrsa.gov (accessed 11.11.2015).
18. DeSilva JJ, Newell LM. Service Lines: To Be or Not to Be? *Health-care Financial Management Association Newsletter.* Fall 2013: 1–4.
19. Hsia RY, Kellermann AL, Shen YC. Factors associated with closures of emergency departments in the United States. *JAMA.* 2011; 305(19):1978–85.
20. Caplan AL. Organ procurement: it’s not in the cards. *Hastings Cent Rep.* 1984;14(5):9–12.
21. United States Conference of Catholic Bishops. Ethical and Religious Directives for Catholic Health Care Services, 5th Edition, Directive 63. 2009.
22. Wicclair M. Conscience-based refusal to participate in donation after cardiac death (DCD). Abstract# 130. *Transplantation.* 2013; 96:S165.
23. 42 US Code of Federal Regulations 482.45 – Condition of participation: Organ, tissue, and eye procurement.