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### e-Ethics, 2000 October

Advocate Aurora Health

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## Organ and Tissue Donation

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In 1998, the Health Care Financing Administration (HCFA) issued revised Medicare Conditions of Participation (CoP) requiring hospitals receiving Medicare funding to report each patient death to an organ procurement organization (OPO). Representatives of the OPO—locally, the Regional Organ Bank of Illinois (ROBI)—then assess each patient's medical suitability for organ and tissue recovery. This development created new ethical concerns for clinical caregivers and health care organizations.

HCFA also gave OPO representatives primary authority to make donation requests. Hospital personnel ("designated requestors") could approach families about donation only after receiving approved OPO training. Since few hospitals have pursued this training option, OPO personnel often function as a hospital's sole requestors.

From an ethical perspective, the values at stake in organ and tissue recovery have not changed. The core value driving donation requests is the socially recognized need to obtain organs and tissues for people facing significant impairment or death without transplants. The request process has always been intertwined with clinical care, whose core values are promoting patient health and well-being and, not incidentally,

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supporting families and others close to patients.

For clinical caregivers, patient care comes first. When, for example, a patient with severe head trauma is admitted to the ICU with little chance of recovery, staff members may recognize an opportunity for organ retrieval. But their immediate focus is optimal care for the patient, which usually includes aggressive life-saving interventions. If such interventions prove nonbeneficial, optimal care, often including palliative measures and family support, is still the first priority.

Once death is imminent or has occurred, however, the donation request process claims a caregiver's direct attention, especially when retrieval of major organs is possible. Decisions associated with maintaining organ viability and requesting donation must be made. In the past, contacting the OPO and requesting donation was considered a worthy but not required course of action. A caregiver's role as principal requestor

allowed discretion when requesting donations: clinicians might deem a patient medically unsuitable to donate or determine that requesting donation would be insensitive to the grieving family. Federal and state "required request" laws did little to change this picture because they usually lacked enforcement provisions. Ultimately, hospitals and staff members controlled the request process, which hinged on their willingness and ability to integrate the legitimate values and practices of patient and family care with the equally valid claims of organ procurement. When conflict arose, the value most likely to be sacrificed was obtaining organs and tissues.

With the revised CoP, significant control of the donation request process has been transferred from hospitals and clinicians to OPO personnel. The OPO now determines medical suitability for donation after each patient death. OPO staff members are usually the only available authorized requestors.

These changes may be serving their purpose. Nationally, the number of recovered organs has risen since the revised CoP became effective. Such preliminary results should not be surprising. OPO personnel, who now learn of more deaths, have the training and experience to manage the donation process effec-



tively. Moreover, even as non-hospital personnel, they can support the care process by being sensitive to the feelings and beliefs of families. They may nonetheless lack the deeper understanding of a particular family that hospital caregivers develop by attending to that family. And because OPO personnel often arrive as newcomers during a crisis, their role and affiliation may be unclear to distraught family members. They may even be perceived as hospital staff members unless—as should happen routinely—they or hospital associates make their identity clear. Given such contingencies, the value of consistently providing optimal care to bereaved families may be at somewhat greater risk than when hospital associates took the lead in the request process.

How can health care organizations and clinical caregivers best respond to the changed donation request context? First, although primary authority to initiate donation requests is vested in OPO representatives, hospitals and health care networks remain morally responsible for the quality of care provided in their facilities. They have a stake in assuring that patient and family care and organ recovery are implemented in such a way that neither process is significantly compromised. Organizational policies—and the actual practice of clinical associ-

ates—should value both processes while preserving the priority of caring for patients and families.

Second, to achieve the twin goals of increasing donations and providing optimal care, hospitals, OPOs, and their respective associates should collaborate and thus support each other to carry out missions and associated tasks. Based on its value of Partnership, Advocate takes such a collaborative approach in its model policy for organ donation. Advocate associates are asked to support ROBI colleagues in the request and recovery process, and when invited they may join ROBI staff members in sensitively approaching family members to discuss donation. A truly collaborative approach and genuinely collegial relationships seem most likely to promote the success of organ recovery, while assuring that appropriate and sensitive care is provided to families throughout the donation process. (See also HCFA's new, informative *Roles and Training in the Donation Process: A Resource Guide*, available at [www.organdonor.gov](http://www.organdonor.gov).)

**e-Ethics** provides discussion of important ethical issues in clinical care and organizational life. In specific cases, fuller ethical analysis may be required. The discussions in E-ethics should not be construed as legal advice and do not necessarily represent official positions of Advocate Health Care.

**To list** an event in the E-ethics calendar, contact Mary Ann Clemens at (312) 266-2222 ext. 240 or [mac@prchfe.org](mailto:mac@prchfe.org).



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