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Ethics in Emergency Medicine

ETHICAL CONTROVERSIES SURROUNDING THE MANAGEMENT OF POTENTIAL ORGAN DONORS IN THE EMERGENCY DEPARTMENT

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□ **Abstract—Background: On a daily basis, emergency physicians are confronted by patients with devastating neurological injuries and insults. Some of these patients, despite our best efforts, will not survive. However, from these tragedies, there may be benefit given to others who are awaiting organ transplantation. Steps taken in the emergency department (ED) can be critical to preserving the option of organ donation in patients whose neurologic insult places them on a potential path to declaration of brain death. Much of the literature on this subject has focused on the utilitarian value of clinical interventions in the potential organ donor to optimize the likelihood of effective organ procurement. Case Presentation: In this article, we present an actual case that reveals additional ethical perspectives to consider in how emergency physicians manage patients in the ED who can be confidently predicted to progress to death, as attested by neurologic criteria, and become organ donors. The case involves a patient with a devastating, nonsurvivable intracerebral hemorrhage who rapidly progressed to hemodynamic instability. Discussion: This case reveals how the current organ donor referral and maintenance system raises ethical tensions for emergency physicians and ED personnel. Conclusion: This process imposes limitations on communication with patient surrogate decision-makers while calling for interventions with the primary purpose of benefiting off-site patients awaiting transplantation.** © **2014 Elsevier Inc.**

□ **Keywords—ethics; organ donation; emergency department; organ procurement; emergency medicine**

INTRODUCTION

On a daily basis, emergency physicians are confronted with patients with devastating neurological injuries and insults (1). Despite our best efforts, some of these patients are destined to die from their intracerebral hemorrhage, ischemic stroke, or traumatic brain injury. Although the tragedy of this event is obvious for the patient and the patient's family, it may result in new hope for individuals awaiting organ transplantation. Emergency physicians commonly are the first doctors to encounter individuals at the interface between life and death, between trying to save the patient and preserving the option of organ donation in the patient who cannot be saved. This is especially true when considering donation after neurologic determination of death, which still represents the primary mechanism for deceased organ donation in the United States (2). Continuous hemodynamic management is required both to verifiably establish that brain death has taken place under established protocols and to maintain organ perfusion to allow effective procurement and transplantation (3).

It is estimated that every day, on average, 18 individuals die awaiting transplantation in the United States (2). There is retrospective evidence suggesting that early organ donor identification from the emergency department (ED) may be associated with increased organ procurement (4). However, this evidence does not take into

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account other ethical viewpoints beyond the utilitarian outcome of maximizing the number of organs procured. In this article, we present a case that reveals other ethical perspectives deserving consideration in how emergency physicians manage patients in the ED who may progress to death by neurologic criteria and become organ donors.

CASE PRESENTATION

A 52-year-old woman presented to the ED having been "found down." Per emergency medical services, she had a history of hypertension that was poorly controlled, and her family found her face down in her bedroom. She was noted to have poor respiratory effort and was intubated without medications prior to arrival at the ED. On examination, the patient had sluggish pupillary reflexes, but otherwise, no significant neurological function. Computed tomography scan revealed a large intraparenchymal hemorrhage with intraventricular extension and severe midline shift.

DISCUSSION

Referral to the Organ Procurement Organization

The first ethical point in the ED management of a patient who is likely to die from a devastating neurological insult is whether or not to make a referral notification for potential organ donation to the local organ procurement organization (OPO). Under Medicare and Joint Commission regulations, hospitals are required to have agreements in place with their local OPO to refer patients at imminent risk of death or who have died after serious neurological insult or injury (5). Common triggers to set potential organ donation in motion include: 1) intubation with consideration of brain death examination or anticipated rapid deterioration to brain death; 2) Glasgow Coma Scale score < 6; and 3) discussions between patient's family members and the emergency physician, initiated by either side, to withdraw life-sustaining treatment (5). Although EDs may be the location for identifying such patients, emergency physicians serve as the referring provider to the OPO, which may create an ethical dilemma and cognitive dissonance.

One role of emergency physicians in the health care system is to aggressively resuscitate patients presenting in extremis and to make medical judgments on when such efforts may be futile. However, once a medical judgment is made that a patient is likely to expire from neurological insult, emergency physicians are precluded by Medicare regulations from discussing organ donation with the potential donor's family without specialized training as a designated requestor (5). The basis of this regulation is evidence that specialized training as a designated requestor leads to a higher rate of consent by grieving family members for organ procurement (6).

Yet, a Department of Health and Human Services Inspector General Report on Medicare's organ donation regulations noted that physicians regularly view the requirement of designated requestor training as an intrusion on their ability to communicate honestly with patient families (6). This report also states that there is little incentive for an OPO to train designated requestors among hospital staff. Medicare holds the OPO ultimately accountable for meeting standards on deceased organ procurement. As a result, few designated requestor-training programs are publicized or offered by OPOs (6).

As this report notes, the implications of the lack of designated requestor training are profound. First, "among hospital staff, the designated requestor requirement may be leading to an unintended result. Rather than moving toward a collaborative approach to requesting consent, this provision runs the very real risk of turning consent into an OPO function, with little involvement from hospital staff. Our survey responses from hospitals and our visits with them supported this finding. Several of the qualitative responses to our hospital survey indicated that their staff members were [sic] happy to turn requesting donation over to the OPO, because the hospital staff felt untrained and uncomfortable in approaching families." Second, "an even more far-reaching problem may be the gradual disenfranchisement of hospital staff from involvement in organ donation. To the extent that nurses and other hospital staff see organ donation as 'the OPO's job', one in which the hospital staff should have no involvement, there is likely to be little true collaboration or interest in organ donation" (6).

Consequently, current Medicare regulations can lead to an untenable situation for emergency physicians. They may have full knowledge that the most likely outcome for a patient is brain death and, with professional expertise, have the necessary skills to communicate this prognosis to surrogate decision-makers, and discuss the options in management needed to permit consideration of organ donation. However, emergency physicians are limited by regulations in what they can communicate to a patient's family regarding organ donation, while simultaneously having an obligation to convey patient information to an outside organization, the OPO. Logistically, if the OPO representative is not readily available, a common occurrence during off-hours and at outlying facilities, the discussion about organ donation may be delayed and the opportunity for donation irretrievably lost (6). Alternatively, the family may be left with a false impression regarding the patient's prognosis as resuscitative measures are continued while awaiting the arrival of the OPO representative.

Such dissonance might be managed internally by the emergency physician by adopting a perspective that