HPNA Position Statement
The Role of Palliative Care in Organ and Tissue Donation

Background

In 1954, the first successful kidney transplant was performed promoting a national awareness of the tremendous potential benefits of organ donation.[1] Since that time, progressive growth in the field of organ transplantation as well as better outcomes have increased the demand for organs. In 2006, approximately 30,000 individuals received organ transplants from approximately 14,000 donors. The numbers continue to grow. Today, nearly 115,000 individuals wait for organs as they experience progressive chronic or serious life-threatening illness.[2] Poor communication, a knowledge deficit, and a lack of family support may contribute to this problem, as many viable organs never become available.[3] Individuals who are fortunate enough to receive organs often live significantly longer with an improved quality of life.[4]

Organs and tissue for transplantation may be obtained from several sources, including a donation from a living individual, a cadaver, a brain-dead donor, and donation after cardiac death (DCD). DCD involves organ procurement following the withdrawal of mechanical ventilation.[5] The majority of the public supports organ and tissue donation, yet donation infrequently occurs within the palliative care or hospice settings.[1]

The DCD donor requires special consideration. This process allows patients who are on life-sustaining measures with a fatal condition to donate organs when death is declared by cardiopulmonary criteria. In these cases, the potential donor is not considered dead and may have the capacity to experience distress before, during, and after ventilator withdrawal until death occurs.[6] After ventilator withdrawal the DCD donor must die within a short interval for the organs to be suitable for donation. Palliative care plays a role in the care of the DCD donor to ensure attention to symptom distress and family support, especially if the patient survives beyond the interval of time for suitable donation or if the organs become unusable.[7,8] When the donation is aborted, the patient and family will require continued palliative care until death.

Organ and tissue donation offers patients and families the opportunity to initiate a legacy, creating "good" out of an often painful experience. Knowing that their gift

is helping another person live often gives meaning to a very difficult experience. This gift may help the family to realize a sense of hope, honor, and progress in what may otherwise seem like a bleak and meaningless period.[7,8] Organs and tissue are often used for transplantation, but they can also be used for research. Sparse literature exists regarding the role that palliative care plays in helping to meet the needs of individuals whose organs are failing.[5] The palliative care team is integral in helping with decision-making and coordination of care. Their role is to provide expert pain and symptom management for the patient and support to the family in decision-making, grief, and through bereavement.[3,7,8]

The economic benefits of organ transplantation are assumed, since only minimal literature exists.

Position Statement

- Hundreds of thousands of Americans suffer progressive chronic or serious life-threatening illnesses, which might be alleviated with appropriate organ and tissue donation.
- Palliative care providers have the skills needed to inform, educate, and support patients/families in the role and need of organ and tissue donation in collaboration with the state organ procurement organization.
- Education and information regarding the donation of organs must be discussed with the patient in the context of advance care planning and advance directives.
- Palliative care providers have the skills to ensure excellent symptom management and comfort care to the dying patient during the time of withdrawal of life support and after.
- Palliative care providers, which includes hospice, need to adopt policies for promoting and obtaining organ and tissue donation when possible.
- Education and research regarding the roles palliative care may play to support organ donation need to be initiated.
- Organ procurement organizations need to partner with palliative care providers to help improve organ and tissue donation as appropriate.
- The standard of care should be followed in withdrawal of life support as for any other patient and that palliative measures are not intended to hasten death.
- Only designated requestors can approach family regarding organ donation, not hospice and palliative nurses as permitted by state law and organizational policy.

Definition of Terms

Brain dead donor: A patient who has been pronounced dead by neurologic criteria and is maintained on mechanical ventilation, parenteral fluids, and other

needed vasoactive medications to support organ perfusion until transplant teams can remove the organs in the operating suite.

Cadaver donor: A patient who has been pronounced dead by cardiopulmonary criteria and may be suitable for tissue donation (e.g., corneas, skin, heart valves, bones).

Donation after cardiac death (DCD) donor: A patient who is not dead and is maintained on mechanical ventilation, parenteral fluids, and other needed vasoactive medications for whom withdrawal of life support is planned and death is expected to occur within a short period of time after withdrawal. Organs suitable for donation after cardiopulmonary death is ascertained may include kidneys, pancreas, and liver. DCD may also be referred to as donation after circulatory death or has been referred in the past as "donation from a non-heart beating donor."[9-11]

References

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Additional Resource

Wijdicks EFM, Varelas PN, Gronseth GS. Evidence-based guideline update: determining brain death in adults: reports of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology*. 2010;74:1911-1918. Available at: www.neurology.org/content/74/23/1911.full.pdf.

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