Australasian College
for Emergency Medicine

Organ and tissue donation

Policy P34

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Document Review

Timeframe for review:	Every three years, or earlier if required.
Document authorisation:	Council of Advocacy, Practice and Partnerships
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Document maintenance:	Department of Policy and Strategic Partnerships

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	January 2004	Approved by Council
V2	March 2006	Content revised and approved
V3	November 2019	Content revised and approved

Supporting documents

- *P733 Policy on Credentialing for Emergency Medicine Ultrasonography*

1. Purpose and scope

This policy articulates the general responsibilities of emergency physicians with respect to the organ and tissue donation process. The principles outlined in this Policy reference and accord with the *Best Practice Guideline for Offering Organ and Tissue Donation in Australia*[1], but have been broadened to enable binational application.

The Policy does not provide clinical advice on donor identification, management or assessment for medical suitability. These aspects should be managed in accordance with relevant clinical, professional and ethical standards.[2,3,4]

The Policy is applicable to emergency departments in Australia and New Zealand.

2. Summary

- ACEM supports the principle of human organ and tissue donation from recently deceased individuals for transplantation to living human recipients. Donation is an element of end-of-life care and is undertaken with respect and dignity for all involved.
- Emergency physicians should be part of a process that identifies patients who are potential donors.
- Specific knowledge is required to support families in decision-making, with information on potential donation delivered clearly, with sensitivity, and in line with individual and cultural needs.
- A team-based approach, involving the treating team, donation specialist staff and other support staff relevant to the family, is critical in planning and conducting the conversation around donation.

3. Identification of potential donors

The opportunity for organ donation is an infrequent event, with donation only possible when a person is on a ventilator in an intensive care unit (ICU), usually with severe brain damage. Less than 1% of all deaths happen this way. In most cases, potential donors are identified in the ICU. However, they are sometimes identified in the ED in circumstances where the patient is unlikely to survive.

For potential donors in the ED referral to the ICU, and notification of hospital donation specialist staff and the responsible national agency, should occur according to the GIVE Clinical Trigger or other hospital protocol. These are used to initiate consultation with ICU medical staff before the withdrawal of treatment in patients with brain injury that is thought to be irrecoverable.

This process must not influence decisions regarding resuscitation nor the continuing management of the patient. Likewise, the maintenance of a potential donor should never compromise the care of other patients in the ED.

1. Organ and Tissue Authority. *Best Practice Guideline for Offering Organ and Tissue Donation in Australia*. Attorney General's Office, Canberra, 2017
2. Australian and New Zealand Intensive Care Society. *The ANZICS Statement on Death and Organ Donation* (Edition 3.2). ANZICS, Melbourne, 2013.
3. Transplantation Society of Australia and New Zealand. Clinical Guidelines for Organ Transplantation from Deceased Donors (Version 1.3). TSANZ, Sydney, 2017.
4. National Health and Medical Research Council. *Ethical Guidelines for Organ Transplantation from Deceased Donors*. NHMRC, Canberra, 2016.

4. Determination of brain death

The ICU – rather than the ED – is the appropriate facility for the diagnosis of brain death.

However, Fellowship of ACEM should be recognised in government regulations as a medical qualification that provides the holder with the authority and skills to perform the determination of brain death. This is particularly important in facilities with no intensive care specialists.

The person determining brain death must not be responsible for authorising or undertaking removal of tissues for the purposes of donation.

5. Communication with the family

End-of-life care and family donation conversations (FDC) are usually best managed in the ICU rather than the ED, and should be provided by a suitably trained person.

If this is not possible it may be necessary to undertake all of the end-of-life care communication with the family within the ED, including offering donation. This would require the attendance of an FDC-trained specialist in the ED.

It is the treating clinical specialist's responsibility to ensure that the family understands and accepts that death has or will occur before any discussion of donation is commenced. The participation of an FDC-trained specialist, who is separate to the treating clinical team, may be beneficial even if the treating clinical specialist has undergone FDC training.

Separation between notification of brain death (or recommendation of treatment withdrawal) and raising the issue of potential donation recognises the need of the family to absorb their loss. This separation has been shown to have a positive impact on consent rates, and ensures that there is no perceived conflict between patient care priorities and donation.

6. FACEM training

On completion of training, as articulated in the ACEM Curriculum Framework, a FACEM will be able to:

- identify a patient as a potential organ donor according to recognised medical criteria;
- notify the organ donation service and inpatient critical care clinicians appropriately; and
- sensitively elicit patient and carer wishes regarding organ donation where appropriate in the ED.

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