Australasian College for Emergency Medicine

Policy on Organ and Tissue Donation

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Document Review

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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	Jan 2004	Approved by Council
V2	Mar 2006	Conent revised and approved
V3	Nov 2019	Conent revised and approved
V4	July 2023	Revised in line with best practice guidance. References updated.

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] with some language broadened to enable binational application.

The Policy does not provide advice on assessing the medical suitability of potential donors, donor management, or the organ and tissue donation and transplantation process. These aspects should be managed in accordance with relevant clinical, professional, and ethical standards.[2,3,4]

The Policy is applicable to emergency departments (EDs) in Australia and Aotearoa New Zealand.

2. Summary

ACEM supports the principle of human organ and tissue donation from recently deceased individuals for transplantation to living human recipients. Offering organ and tissue donation should be considered a routine part of end-of-life care in hospitals.

Emergency physicians should be part of a process that identifies patients who are potential donors. As such the ED team should have a system in place to facilitate organ and tissue donation opportunities.[5]

Specific training, communication skills and knowledge are required to support families/whānau in decision-making around organ and tissue donation, with information on potential donation delivered clearly, with sensitivity, and in line with individual and cultural needs.

All hospitals should have access to services that record and make immediately available a patient's intentions regarding donation.

A team-based approach, involving the treating team, donation specialist staff and other support staff relevant to the family/whānau, is critical in planning, conducting, and learning from the conversation around donation.

3. Referral of potential donors

The opportunities for organ donation are infrequent, and only possible when a person is on a ventilator, usually with severe neurological damage. Less than 1% of all deaths happen this way. In most cases, potential donors are identified in the Intensive Care Unit (ICU). However, they are sometimes identified in the ED in circumstances where the patient is unlikely to survive.

In Australia, patients in the ICU and ED for whom there is medical consensus for planned end-of-life care should be referred as soon as possible to DonateLife (directly or via the hospital Donation Specialist staff). Referral enables DonateLife to assess suitability for donation, check the patient's registration status on the Donor Register, and facilitate the involvement of a Donation Specialist Nurse to support planning and family/whānau communications.

In Aotearoa New Zealand, the LINK team operates in all public donating hospitals and provides the connection between the hospital and Organ Donation New Zealand's donor coordinators. LINK teams are comprised of an ICU nurse, ICU doctor and an operating theatre nurse, and are the local leaders, experts and liaison persons for organ and tissue donation in all donor hospitals in Aotearoa New Zealand.

The referral of a patient to donation staff/agencies must not influence decisions regarding resuscitation nor the continuing management and care of the patient. Likewise, the maintenance of a potential donor should never compromise the care of other patients in the ED.

4. Determination of neurological death

The ICU, rather than the ED, is the appropriate place for the diagnosis of neurological 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 neurological death. This is particularly important in facilities with no intensive care specialists.

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

5. Communication with the family/whanau

End-of-life care and family donation conversations (FDC) are best managed in the ICU rather than the ED and should be provided by a suitably trained person. For potential donors in the ED, referral to the ICU should occur according to hospital protocols and practices.

On the rare occurrence that communication with the family/whānau around donation needs to take place in the ED, the attendance of the Senior Treating Doctor (the treating emergency physician or senior decision maker) and the FDC-trained specialist is required.

In regional and remote hospitals, local hospital guidelines may provide advice regarding other hospital-based staff who have been identified to assist in donation conversations. The national donation agency will also be able to provide telephone support to regional and remote hospital staff that can assist when undertaking donation discussions with families/whānau.

It is the Senior Treating Doctor's responsibility to ensure that the family/whānau 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 from the treating clinical team, may be beneficial at this stage even if the Senior Treating Doctor has undergone FDC training.

Separation between notification of neurological 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 (by time, location, and responsible staff) 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.

The discussion of death and organ donation should include, as appropriate, asking the family/whānau and/or their nominated religious or cultural leader if there are any customary practices at the end of life.[6]

A team planning meeting should occur before each family donation conversation process, and a team review conducted afterwards to reflect upon the approach taken, with a view to continually improving practice.[7]

6. Related ACEM Resources

P455 Policy on End of Life and Palliative Care in the Emergency Department

7. References

1. Organ and Tissue Authority. Best Practice Guideline for Offering Organ and Tissue Donation in Australia. Attorney General's Office, Canberra, 2021
2. Australian and New Zealand Intensive Care Society. The ANZICS Statement on Death and Organ Donation (Edition 4.4). ANZICS, Melbourne, 2021.
3. Transplantation Society of Australia and New Zealand. Clinical Guidelines for Organ Transplantation from Deceased Donors (Version 1.10). TSANZ, Sydney, 2022.
4. National Health and Medical Research Council. Ethical Guidelines for Organ Transplantation from Deceased Donors. NHMRC, Canberra, 2016.
5. Australasian College for Emergency Medicine. Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services (Standard 1.9, Objective C). ACEM, Melbourne, 2022.
6. Australian and New Zealand Intensive Care Society. The ANZICS Statement on Death and Organ Donation (Edition 4.4, Section 3.5 Cultural Humility). ANZICS, Melbourne, 2021.
7. Organ and Tissue Authority. Best Practice Guideline for Offering Organ and Tissue Donation in Australia (Appendices C & D, FDC Planning and Review Templates). Attorney General's Office, Canberra, 2021.

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