

TRILLIUM GIFT OF LIFE NETWORK (TGLN)

Medical Assistance in Dying (MAID) Provision and Donation after Cardio-Circulatory Death (DCD)

TGLN's mission is to save and enhance more lives through the gift of organ and tissue donation in Ontario, including helping people realize their end-of-life wish to donate organs and tissue as part of their medically-assisted death. The donation process resembles that of a traditional DCD with some variation given the intersection of medical assistance in dying. The goal of this document is to provide guidance and minimize practice variation from the standard medically-assisted death while still allowing donation to happen efficiently with the least impact on the patient and healthcare team.

Frequently Asked Questions from Designated Hospitals and Healthcare Professionals (HCP)

How does TGLN plan the Patient Donation Discussion/Approach with the Primary Clinician?

A specialized coordinator at TGLN will work with the Primary Clinician from the initial notification onwards to:

1. Understand the status and timing of the medical assistance in dying process
2. Assess health history prior to approach to determine eligibility to donate
3. Develop a plan together to discuss donation with the patient ensuring it is minimally disruptive and respectful of the patient's wishes

If the patient is being admitted to the hospital from home to which unit are they admitted?

When possible, individual hospital policy should be followed when determining the admission location. TGLN will work with the hospital to determine the optimal admission location if necessary. Ideally, admission location should be based on both patient preference and proximity to the operating suite to facilitate the medically-assisted death and organ donation, rather than the designation of an accepting service or physician.

Where will the medically-assisted death occur?

For organ donation to occur, death must take place in the hospital in proximity to the operating suite where monitoring can occur. It is recommended that the medically-assisted death take place in the same location that withdrawal of life support occurs during a traditional DCD, as outlined in the hospital's DCD policy. If the hospital has a designated area for medically-assisted deaths, which is also near the operating suites and has monitoring capabilities, it would be suitable to use that location in the context of organ donation following the medically-assisted death.

Does the critical care team need to be involved?

The critical care team are the local experts in donation and TGLN will help facilitate a consult with the Hospital Donation Physician (HDP) to help answer any questions. If the patient is not admitted into a critical care area, the critical care physician may be called upon to insert the arterial line if appropriate.

What is the minimal amount of blood work required to assess organ suitability?

Minimal baseline blood work (i.e. Group and screen, CBC, electrolyte profile, liver profile, etc.) will be obtained following the provision of consent for donation to assess for organ and tissue suitability. The TGLN coordinator will work to ensure that the testing process is as minimally disruptive to the patient as possible.

What additional tests may be required to assess organ suitability?

The TGLN coordinator will advise what additional tests are required to assess organ suitability. These may include but are not limited to:

- Urinalysis
- Urine albumin to creatinine ratio
- Urine culture
- Chest x-ray
- Abdominal ultrasound

*A pre-mortem bronchoscopy will not be required as part of the suitability assessment if lungs are being considered for transplant. However, an intraoperative bronchoscopy will be performed following death if the lungs are suitable for transplant.

Final determination of organ suitability for transplantation is made by individual transplant programs.

What additional blood work is required after confirmation of organ acceptance?

Upon acceptance of an organ by a transplant team, and under the direction of the TGLN coordinator the following additional testing is required:

- Blood cultures (one set)
- Blood samples for serology and human leukocyte antigen (minimum amount required)
 - TGLN coordinator to provide blood tubes and arrange for transport to external lab
- Repeat baseline blood work only if requested by accepting transplant team

Does the patient require hemodynamic monitoring?

No. If the patient is hemodynamically stable, they do not require invasive hemodynamic monitoring as part of standard donor management. Vital signs (HR, BP, T, SPO2) and intake and output volumes can be monitored at a minimum of q12 hours or as frequently as the nurse collects them.

The medical assistance in dying provider may be asked to administer a large dose of heparin prior to organ donation

Heparin administration is common for all organ donors and increases the number and quality of organs that can be donated.

Informed consent for heparin administration is obtained from the patient by the TGLN Coordinator. Heparin dosing is determined by the transplant team and will be communicated via the TGLN Coordinator. Heparin is administered shortly (approximately 5 minutes) before the medically-assisted death to allow circulation time.

What is the most acceptable way to declare death following the provision of medical assistance in dying?

Declaration of death by circulatory criteria is required for organ donation following a medically-assisted death. The preferred method is to document an absent pulse pressure by arterial line and absent respirations by direct observation. Upon cessation of spontaneous circulation, a five-minute, hands off observational period will take place to confirm the continuous absence of pulse pressure as monitored by an arterial line, no respiratory effort and no palpable pulse at the beginning or end of the five-minute period. In the absence of consent for an arterial line the TGLN coordinator will connect you with the Donation Support Physician (DSP) to provide advice on the acceptable alternative for declaring death.

In Ontario, the *TGLN Act* governs the practice of organ and tissue donation and states that for the purposes of post mortem transplantation, death must be determined by two physicians. One declaring physician must also be independent of the medical assistance in dying process and approval.

Can the medical assistance in dying provider, if an anesthetist, also be the intubating anesthetist if the lungs are accepted for transplant?

Yes. Like when lungs are accepted for transplantation following traditional DCD, if the medical assistance in dying provider is an anesthetist they can intubate the patient for the purposes of lung donation following the medically-assisted death and the declaration of death by two physicians.

The anesthetist will also be required to assist with the intraoperative bronchoscopy and management of the ventilator during the recovery period until the trachea is clamped. Lung recruitment manoeuvres are also required throughout the procedure. The approximate time commitment is one hour or less from commencement of donor organ recovery.