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**CASE AND COMMENTARY**
**Organ Donation: When Consent Confronts Refusal**
Commentary by John C. Moskop, PhD

**Case**
Dr. Nichols is a third-year emergency medicine resident in a community teaching hospital. One Friday afternoon, while he was working in the emergency department, the desk operator sought him out and reported that an EMT unit was on its way in with a motor vehicle injury patient. A motorcyclist apparently hit a concrete median while taking a turn and was thrown from his bike. He had not been wearing a helmet. When the rescue squad arrived, the patient was not breathing. Life support measures were begun, and the patient was intubated in the field.

Dr. Nichols notified the trauma center on-call neurosurgeon about the incoming patient. When the patient, Derek Polaski, arrived, he was taken to the "crash" room. He had serious head injuries and was hypotensive. Dr. Nichols got a CT scan of the head to determine the extent of Mr. Polaski's injuries. The neurosurgeon arrived, performed a thorough neurologic examination, and looked at the CT scan. He reported to Dr. Nichols that Mr. Polaski was deeply comatose, lacked brain stem reflexes, and had no respiratory drive. He also pointed out that the CT scan showed massive brain injury and severe intracranial bleeding. The injuries were so severe that surgical intervention would be futile.

The neurosurgeon asked that Mr. Polaski be admitted to an ICU bed. When Dr. Nichols inquired about that, he was told that it would be several hours before an ICU bed would be available. The neurosurgeon reflected a moment, then asked that the patient remain in the ED. He explained that the patient was almost certainly brain dead. Ordinarily, he said, he would wait 24 hours before doing a repeat neurologic exam and pronouncing the patient dead. In this case, however, since both the cause and the extent of the brain injury were clearly established, he would return later in the afternoon, repeat the neurologic exam and, barring an unexpected change, pronounce the patient dead.

The neurosurgeon did return, performed the required examination, and pronounced the still-intubated patient dead at 6:20 PM, 4 hours after his arrival in the ED.

An ER orderly had informed Dr. Nichols that Mr. Polaski's driver's license indicated he wanted to be an organ donor. Dr. Nichols asked that the contact person for the organ retrieval team be notified. At 6:45, Mr. Polaski's wife arrived at the

ER, having been met at her door by 2 police officers when she arrived home from work.

It fell to Dr. Nichols to tell her about her husband's injuries and that he was brain dead. This was not easy. Mrs. Polaski hadn't seen her husband with his injuries (which sometimes makes it easier to believe the news); last she saw him he was perfectly fine. Dr. Nichols had to say more than once to her wide, disbelieving eyes, "Mrs. Polaski, your husband is brain dead." She didn't break down or cry.

It wasn't until the organ procurement coordinator from the Gift of Hope Organ Procurement Organization spoke to her about her husband's wish to donate his organs that Mrs. Polaski seemed to understand what was happening. The officer was kind, but he asked Mrs. Polaski to say her final good-bye to her husband and mentioned that the organ team could take Derek's body as soon as Mrs. Polaski "was comfortable" with them doing so. Mrs. Polaski was disbelieving and furious.

"What do you mean, he's dead?" she asked. "He's breathing. He's not cold or even pale. He's not dead."

"His brain is not functioning, Mrs. Polaski," Dr. Nichols stepped in to explain. "He can't breathe or do anything else on his own."

"Well, fine. Just leave him on that machine. He's not dead. I can see he's not dead. He doesn't look like dead people look. Don't touch him."

Dr. Nichols tried a couple more times to explain, but Mrs. Polaski said, "Even if he really does die, that doesn't mean you can cut him open and take his organs. I'm his wife. You have to give his body to me, and I don't want it all cut up and mutilated. I won't let you do it."

Dr. Nichols discovered that he was saying the same thing over and over—"your husband is dead and he wanted to help another person live by donating his organs." He could not bring himself to say, "We don't need your permission to take your husband's organs. We can take them on the basis of the signed intent to be an organ donor on his license."

Surprisingly, this was Dr. Nichols' first experience with an intended donor whose organs were satisfactory for transplant and whose family opposed the donation. Knowing that Mr. Polaski's organs were safely ventilated and perfused, Dr. Nichols tried to buy time. The team surgeon reassured Dr. Nichols that a signed donor card or driver's license served as a legal instrument (like a will) in their state. All 50 states, in fact, have adopted the 1987 Uniform Anatomical Gift Act, which established this guideline for organ procurement. Their own hospital policy quoted the state statute, the surgeon told Dr. Nichols, and protected physicians who retrieved organs over the objection of family members, as long as a signed donor card or license was present on the deceased. The hospital policy, however, did not

stipulate that physicians *must* override family members' objections. The policy stated that its physicians were free to act in response to circumstances that were "unique" to the case.

The hospital policy was similarly lenient regarding removal of brain-dead patients from ventilators. Under certain circumstances, such patients could be left on ventilators long enough for family members to arrive and see them. The length of time should not be "excessive," but, again, was left to the "judgment of the hospital's trusted physicians."

Dr. Nichols didn't want to give up on retrieving Mr. Polaski's organs, yet he doubted that a few hours—even 24—would change Mrs. Polaski's mind. It didn't seem right to do nothing. Mr. Polaski's interest and the interests of the potential donors who could receive his organs were on 1 side of the balance, with only Mrs. Polaski opposing them. Yet, here she was, the 1 person alive in front of him pressing her strong objection to the use of her husband's organs.

**Commentary**

In this case, Dr. Nichols confronts a difficult decision about organ procurement from a heart-beating cadaver donor. Fortunately for emergency physicians, such decisions do not often arise in the emergency department (ED), since most critically injured patients are swiftly transferred to an intensive care unit, where determination of brain death occurs after additional treatment efforts. Nevertheless, a large percentage of transplant organs are obtained from patients with severe trauma resulting in death. Many of these patients will receive initial care in the ED, and so emergency physicians should be familiar with policies and procedures for organ donation and procurement from cadaver donors.

Dr. Nichols clearly has a beneficent motive for his efforts to obtain Mr. Polaski's organs for transplantation. Moreover, Dr. Nichols has learned that Mr. Polaski had expressed his willingness to be an organ donor on his driver's license. The patient's wife, however, strenuously resists both the assertion that her husband is dead and the proposal that his organs be removed for transplantation.

The immediate question for Dr. Nichols, of course, is "How should I proceed?" Before we address that question, however, let's consider 2 prior questions. First, who should take the lead in communicating with Mrs. Polaski? Second, what role should Dr. Nichols, the emergency medicine resident, play in this process? In response to these "prior questions," let me state my position at the outset. I believe that informing Mrs. Polaski that her husband is dead and discussing the question of organ donation with her should be undertaken by different professionals and that Dr. Nichols should not play the lead role in either activity. These 2 activities should be separated to avoid any perception of a conflict of interest between caring for Mr. Polaski and using his organs to benefit other patients. Thus, the caregivers who diagnose and treat Mr. Polaski's condition should be clearly distinguishable from those who pursue organ procurement and transplantation.

The case states that "it fell to Dr. Nichols" to tell Mrs. Polaski about her husband's death, but it does not say why this is so. Information so sensitive and emotionally laden should, I believe, ordinarily be given by the physician who performed the required neurologic examinations establishing the diagnosis. Only this physician can provide specific answers to the wife's questions about how her husband's death was established. Moreover, this physician is likely to have a great deal more experience and expertise in communicating this particular information to family members than an emergency medicine resident. In the present case, the neurosurgeon might have been called away to another patient before Mrs. Polaski arrived at the ED. If that were the case, I believe that an attending emergency physician should have assumed this weighty disclosure responsibility, with Dr. Nichols' assistance. As described in the case, it appears that an organ procurement coordinator from the local organ procurement organization (OPO) did take the lead in discussing organ donation with Mrs. Polaski. This is appropriate, since the coordinator will have considerable experience in discussing this issue with family members and will be able to provide specific answers to questions Mrs. Polaski may have about the organ procurement and donation process. In many states, laws require that hospitals refer all potential donors to the local OPO for review and follow-up. Mrs. Polaski should also, of course, have access to Dr. Nichols or another member of her husband's care team to answer her questions about her husband's condition and treatment.

The case narrative does not include a detailed description of the caregivers' discussions with Mrs. Polaski, but 2 of the statements that are reported give cause for concern. First, Dr. Nichols is reported to say several times to Mrs. Polaski, "Your husband is brain dead." Many commentators recommend avoidance of the term 'brain dead', since it is widely misunderstood. Use of this term may suggest that there is a difference between "brain death" and death of the person, and thus allow family members like Mrs. Polaski to conclude that their loved one is not dead. Instead, Dr. Nichols, or preferably the neurosurgeon, should tell Mrs. Polaski that her husband is dead and explain that his death was established based on neurologic criteria, that is, irreversible loss of brain function.

Second, the organ procurement coordinator is reported to tell Mrs. Polaski that the organ team would "take Derek's body" as soon as she "was comfortable" with that. This statement may well have given Mrs. Polaski the mistaken idea that if she agreed to organ donation, she would permanently lose control of her husband's body. That might explain her later insistence that "you have to give his body to me, and I don't want it all cut up and mutilated." Instead, the organ procurement coordinator should have reassured Mrs. Polaski that she would retain control over her husband's body and that organ donation does not disfigure the body or interfere with an open casket funeral. A different approach to discussion of her husband's death and of the option of organ donation might have persuaded Mrs. Polaski to give her consent to donation.

Given the fact of her denial that her husband is dead and her objection to taking his organs for transplantation, however, should the organs be procured against her wishes? The decision to procure an organ is a responsibility of the OPO. A survey of the 61 US OPOs published in 2001 revealed widespread diversity in consent practices for cadaveric organ donation.[1] Despite this diversity, however, only 5 OPOs (8 percent) reported that they were likely to procure organs based on a person's wishes as indicated on a driver's license, if the next of kin objected to donation.

One might view most OPOs' reluctance to procure organs based on a person's driver's license as a violation of the person's moral right to donate. Or one might view this reluctance as recognition of the limits of this method for expressing one's wishes. Mr. Polaski's driver's license evidently expresses his general wish to be an organ donor. If, however, he could have foreseen the current situation, including his wife's shock, suffering, and inability to come to terms with his sudden death, would he still insist on immediate procurement of his organs despite her objections? Or would his concern for her well-being incline him to want her wishes to be honored, or, at least, want to give her more time to accept the fact of his sudden death? Time, and additional discussion, may help her to accept that fact and to carry out his wish to be an organ donor. Even if it does not, however, concern for her well-being offers a persuasive reason for sensitivity to Mrs. Polaski's wishes in this tragic situation.

**References**

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John C. Moskop, PhD is a professor of medical humanities at The Brody School of Medicine, East Carolina University, and director of The Bioethics Center, University Health Systems of Eastern Carolina. Dr. Moskop is also a member of the Ethics Committee of the American College of Emergency Physicians.

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