COURSE OBJECTIVE: The purpose of this course is to provide an overview of the clinical aspects of organ and tissue donation and recovery, focusing on the barriers to organ and tissue procurement and ways to overcome those barriers.

LEARNING OBJECTIVES:
Upon completion of this course, you will be able to:

• Differentiate which organs can be transplanted from deceased versus living donors.
• Describe the scope of the problem of organ and tissue procurement in the United States.
• List three barriers to successful organ and tissue procurement among the public and healthcare professionals.
• Describe interventions nurses can use to overcome those barriers.

INTRODUCTION

In 2012, over one million tissue transplants and over 28,000 organ transplants were done in the United States, with over 78% of those organs coming from deceased donors (DonateLife, 2013; DHHS, 2013b). However, some experts have noted that, ironically, the success of the transplant program in the United States is to blame for the recent shortage of available organs: the improved survival of transplant recipients has caused more doctors and patients to opt for transplant. But the supply of transplantable organs has not kept up with this increased demand (Klein et al., 2010). As a result, about 18 people die each day due to a lack of donated organs (DHHS, 2013a).

To combat this, many organizations and governmental bodies have adopted measures to increase awareness of the organ shortage and improve donation rates.
Most organ donations come from deceased donors, but a living donor can donate a single kidney or part of a liver, lung, pancreas, or intestine. A single deceased donor can save up to eight lives via organ donation (DHHS, 2013a). Tissues can also be transplanted. Unlike organs, which need to be used within hours of harvesting, tissue can be stored for later use.

<table>
<thead>
<tr>
<th>ORGANS AND TISSUES AVAILABLE FROM DECEASED AND LIVING DONORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From Deceased Donors</strong></td>
</tr>
<tr>
<td><strong>Organs</strong></td>
</tr>
<tr>
<td>• Heart</td>
</tr>
<tr>
<td>• Lungs</td>
</tr>
<tr>
<td>• Liver</td>
</tr>
<tr>
<td>• Intestines</td>
</tr>
<tr>
<td>• Kidneys</td>
</tr>
<tr>
<td>• Pancreas</td>
</tr>
<tr>
<td><strong>Tissues</strong></td>
</tr>
<tr>
<td>• Heart valves</td>
</tr>
<tr>
<td>• Bone</td>
</tr>
<tr>
<td>• Cornea</td>
</tr>
<tr>
<td>• Skin</td>
</tr>
<tr>
<td>• Ligaments</td>
</tr>
<tr>
<td>• Tendons</td>
</tr>
<tr>
<td>• Cartilage</td>
</tr>
<tr>
<td>• Veins</td>
</tr>
<tr>
<td>• Middle ear</td>
</tr>
</tbody>
</table>

*It is very rare, but a living person can donate a heart in one instance: a person with a healthy heart but severe lung disease often will do better with a combined heart-lung transplant rather than simply a lung transplant. In this case, the patient receiving the heart-lung transplant can donate her healthy heart to someone else.

**CASE**

Estella is a veteran nurse in the emergency department at a busy inner-city trauma hospital. Late one night, several people involved in a multicar traffic accident arrive. Among the patients is Roland, a 35-year-old man with multiple head injuries, a temperature of 97.8 °F, a pulse of 50 bpm, a respiratory rate of 10, a blood pressure of 60/40, and a Glasgow Coma Scale score of 3. While going through his personal belongings, Estella finds his driver’s license, which states that he is an organ donor. She alerts the ED physician of this fact and calls the nurse specialist, JoAnn, who works as part of the hospital organ donation team. (continues)
SCOPE OF THE PROBLEM

In the United States, there are 58 organ procurement organizations (OPOs). These are independent or hospital-based organizations that are responsible for obtaining donated tissues and organs.

In 1984, Congress passed legislation creating the Organ Procurement and Transplantation Network (OPTN). Under the OPTN, all of the OPOs and the many transplant centers were unified into one network to better coordinate their activities. The OPTN is responsible for maintaining the national transplant waiting list, coordinating organ and tissue matching and placement, collecting and distributing data about organ donation and transplantation, and developing standard procedures for organ procurement and distribution. The United Network for Organ Sharing (UNOS) administers the OPTN (DHHS, 2013c).

Shortage of Organs

Despite this well-organized network and the large number of people who are willing to donate organs, the United States faces a critical shortage of viable organs for transplant. Using data from OPTN/UNOS, researchers found several worrisome trends in the decade from 2001 to 2010 (Saidi et al., 2012).

- Despite an increasing population, donations from living donors peaked in 2004 and then decreased.
- Donations from donors after brain death decreased as well, while donations from donors after circulatory death increased. This is significant, as the latter group tends to produce organs of marginal quality, which consequently negatively affects survival of the organ recipient.
- Organ donation from racial and ethnic minorities has been especially poor. This is important in transplantation because, for many organs, results are better when the race or ethnicity of the donor matches that of the recipient. Minorities are also at increased risk for diseases that result in need for transplantation, and they are disproportionately represented on transplant waiting lists. In 2008, African Americans accounted for 16% of deceased organ donations, but they accounted for 34% of the waiting list for kidney transplants (Bratton et al., 2011). More recently, in an analysis of OPTN data from 2008–2011, there are substantial differences in the rates of consent for organ donation among minorities: 77.0% for whites, 67.5% for Hispanics, 54.9% for African Americans, and 48.1% for Asians (Goldberg et al., 2013).

To help increase the total number of donations, especially in the minority populations, the OPTN organized a series of Breakthrough Collaboratives in 2003 (DHHS, 2013c). These collaboratives included OPOs, transplant centers, representatives from the U.S. Department of Health and Human Services, and other stakeholders.
Initially, it seemed that the collaboratives made a difference. The number of deceased donations increased until 2008, but it has been relatively flat since then. Likewise, after an initial increase in Hispanic and African American deceased donation, the numbers of deceased donations across all racial and ethnic groups declined after 2007 (Bratton et al., 2011; Klein et al., 2010).

The graph below gives one look at the disparity between the need for and the supply of organs.

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**BARRIERS TO DONOR RECRUITMENT**

**Barriers among the General Public**

One reason for the shortage of organs and tissues is that there are many barriers to donation in the general public. Multiple studies have elucidated the various barriers to deceased donation, which cluster into a few identifiable groups.

**LACK OF CLARITY ABOUT DECISION-MAKING AUTHORITY**

The first group of barriers concerns the deceased’s wishes and the responsibility of the surviving family to make the ultimate decision. Despite the wishes of the deceased, the family members must be asked and give consent for organ and tissue donation in the United States. This is not true in all countries, however, as many European nations have a “presumed” consent law pertaining to organ donation (Walker et al., 2013).
The difference in cadaveric organ donation is significant between those nations that have presumed-consent or opt-out laws (citizens are organ donors unless they register not to be) and those that have explicit-consent or opt-in laws (nobody is an organ donor unless they register to be one). In a study of European organ donation legislation, countries with a presumed-consent policy have a cadaveric organ donation rate that is over six times higher than countries without such a policy (Gimbel et al., 2003).

And in nations with opt-in laws, sometimes the wishes of the deceased are not followed. In many cases, if the deceased expressed a desire to not donate, then the surviving family complied. When the wishes of the deceased are not known, family members usually opt to not donate. But even when the deceased signed an organ donor card or made his wishes known, the surviving family sometimes does not opt to donate (Anker et al., 2010; Walker et al., 2013).

**BELIEF SYSTEMS**

The second group of barriers may explain why families choose not to donate: their belief systems. Many non-donors cite religious beliefs as the basis for their decisions. Others cite cultural beliefs, such as respect for the dead or a feeling that the deceased has “been through enough already” (Anker & Feeley, 2010; Morgan et al., 2008b; Walker et al., 2013). Interestingly, one researcher found that religion was cited more frequently as a reason to sign the organ donor card than as a reason not to sign (Morgan et al., 2008a).

In fact, in a review of major religious groups’ positions on organ donation, Gillman (1999) found that most major religions not only allow organ donation, but also often encourage it. The following table summarizes the official position of many major religions.

<table>
<thead>
<tr>
<th>Faith Community</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Methodist Episcopal</td>
<td>Donation is supported</td>
</tr>
<tr>
<td>Amish</td>
<td>Donation is allowed</td>
</tr>
<tr>
<td>Assembly of God</td>
<td>No official position; donation is an individual decision</td>
</tr>
<tr>
<td>Baptist</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>Brethren</td>
<td>No official position; donation is supported as long as it does not hasten the death of the donor or come from an unborn child</td>
</tr>
<tr>
<td>Buddhism</td>
<td>No official position; donation is an individual decision</td>
</tr>
<tr>
<td>Catholicism</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>Confucianism</td>
<td>Donation is forbidden (the body is a gift and damaging it is not allowed)</td>
</tr>
<tr>
<td>Disciples of Christ</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>Christian Science</td>
<td>No official position; donation is an individual decision</td>
</tr>
<tr>
<td>Episcopal</td>
<td>Donation is supported and encouraged</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Religious Group</th>
<th>Position on Donation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greek Orthodox</td>
<td>Donation is supported</td>
</tr>
<tr>
<td>Hindu</td>
<td>Donation is allowed and is an individual decision</td>
</tr>
<tr>
<td>Independent Conservative Evangelical</td>
<td>No official opposition to donation; donation is an individual decision</td>
</tr>
<tr>
<td>Islam</td>
<td>Not universally accepted; the majority of Muslim scholars support donation</td>
</tr>
<tr>
<td>Jehovah’s Witnesses</td>
<td>Donation is an individual choice, but all blood must be removed from the organs and tissues before being transplanted</td>
</tr>
<tr>
<td>Judaism</td>
<td>All four branches support and encourage donation</td>
</tr>
<tr>
<td>Lutheran</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>Mennonite</td>
<td>No official position; donation is an individual decision</td>
</tr>
<tr>
<td>Moravian</td>
<td>No official position; donation is an individual decision</td>
</tr>
<tr>
<td>Mormon</td>
<td>Donation is an individual decision</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>Donation is an individual decision</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>Quakers</td>
<td>No official position; donation is an individual decision</td>
</tr>
<tr>
<td>Seventh-Day Adventist</td>
<td>Donation is supported and strongly encouraged</td>
</tr>
<tr>
<td>Shinto</td>
<td>Donation is discouraged (it is a serious crime to injure a dead body)</td>
</tr>
<tr>
<td>Sikh</td>
<td>Donation is seen as an altruistic act</td>
</tr>
<tr>
<td>Taoism</td>
<td>No official position, but donation is probably allowed</td>
</tr>
<tr>
<td>Unitarian Universalist</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>United Church of Christ</td>
<td>Donation is supported and encouraged</td>
</tr>
<tr>
<td>United Methodist</td>
<td>Donation is supported and encouraged</td>
</tr>
</tbody>
</table>


### COGNITIVE REASONS

A third group of reasons is known as cognitive reasons, or knowledge and attitudes about organ donation. Many people simply don’t know of the need for organs and tissues and have little knowledge about the process. Some think that obtaining the organs will mutilate the body beyond recognition. Others think the deceased’s organs are not useful to anyone, especially after a chronic illness, and are not aware of the variety of tissues that can be harvested. And some misunderstand the meaning of brain death, thinking that the deceased still has a chance to “recover” (Anker & Feeley, 2010). Given time and education, however, some families were able to reconsider and agree to donation (Walker et al., 2013).
NONCOGNITIVE REASONS

Perhaps more powerful than the cognitive reasons are the noncognitive reasons, or emotional reasons, most of which have little or no basis in reality. Some of these factors have been identified: the “ick” factor (a feeling of disgust with the donation process), the “jinx” factor (a superstition that signing the organ donor card is inviting bad luck), and the feeling of wanting to maintain bodily integrity (Morgan et al., 2008b; O’Carroll et al., 2011).

A commonly stated reason for nondonation is medical mistrust, especially among minorities. Some feel that death will be hastened in order to “harvest” organs, that there is a black market for organs, or that the waiting list is not prioritized correctly (Anker & Feeley, 2010; Morgan et al., 2012; Morgan et al., 2008a; Morgan et al., 2008b).

Some refuse to sign an organ donor card due to the worry that the possible recipient may be “unworthy” because he may have brought on the organ failure through bad choices or is simply a “bad person” (Morgan et al., 2008a).

HOW THE DISCUSSION ABOUT DONATION IS INITIATED BY HEALTHCARE PROVIDERS

The final group of barriers to donation is the most critical for nurses: the role of the healthcare team. Family members of the deceased were more likely to donate if they had trust in and a positive relationship with the healthcare team caring for the patient before death. Of utmost importance was the person initiating the discussion about organ donation. Family members were more likely to donate if the requestor was a member of the OPO and not a member of the primary medical team (Anker & Feeley, 2010; Rodrigue et al., 2006; Walker et al., 2013). The one exception to this rule is pediatric organ donation. Family members of a deceased child preferred the discussion be initiated by a member of the healthcare team that was familiar to the family (Walker et al., 2013).

Timing and family support are important parts of the organ donation request. In general, families donated more frequently when the request was made after clear communication of a definitive diagnosis of brain death or cardiac death was made. And families were more likely to donate if given plenty of support, sometimes in very practical ways, such as the provision of blankets, showering facilities, toiletries, time to say goodbye to the deceased, and the demonstration of compassionate care by the healthcare team (Anker & Feeley, 2010; Rodrigue et al., 2006; Walker et al., 2013).

CASE (continues)

In the ED, the team has been working on the accident victim. His wife, Jackie, was at home and was called to the ED. She arrives while resuscitation efforts are underway. Estella provides her with a quiet place to rest and talk while the team works. She calls for a chaplain to talk with Jackie and gets her something to eat and drink. After the team declares the victim brain dead, Estella sits with Jackie, holding her hand while she cries and listening to her talk about her dead husband. After Jackie is a little calmer, Estella calls JoAnn, the nurse specialist with the organ procurement team, to talk with Jackie about organ donation.
JoAnn discusses with Jackie the process of organ donation. At first, Jackie is unsure about donation. She is concerned about the physical appearance of her husband after the organs are obtained. She knows he wanted to be an organ donor but wonders if she is able to make this decision on her own at this time. JoAnn reassures Jackie that if her husband’s organs are donated, he can still have an open-casket funeral. JoAnn notes that organ donation is one way for some good to come of this horrible accident. She states that she understands how difficult this is for Jackie and leaves her some printed material about organ donation. She asks if Jackie needs anything else and offers to come back later. She gives Jackie her pager number and tells her to call if she has any questions.

(continues)

**BARRIERS TO LIVING DONATION**

Beyond the barriers to deceased organ and tissue donation described above, there are additional barriers to living donation. In a meta-analysis of 47 studies of living organ donation, researchers found that many people simply didn’t know this was an option. Most did not want to donate to an unknown recipient. Others were reluctant to become living donors due to fears of surgical or health risks, lack of knowledge of the process, desire to avoid damage to their bodies, distrust in hospitals, fear of scarring, financial loss (due to time off of work), and fear that the transplant would not be successful. However, the vast majority of the public is in favor of living organ donation (Tong et al., 2013).

**Barriers to Recruitment among Healthcare Professionals**

In addition to barriers among the general public, barriers to organ and tissue donation are found among healthcare professionals. Nurses clearly support deceased organ donation, but some nurses feel a conflict of interest in providing the ongoing care to a cadaver after circulatory death (Lindsay, 1995; Hart et al., 2012). Monforte-Royo & Roque (2012) understand this conflict, but advise nurses that dignity does not end with death and that nurses are compelled to treat the deceased donor as they would want to be treated.

Another frequently cited barrier is a lack of knowledge and education about the organ donation process. Even in ICU settings, there are often myths and misunderstandings about contraindications to organ donation. One study found that 41% of ICU nurses incorrectly assumed that brain-dead patients with underlying diseases could not donate their organs (Lin et al., 2010). Another study found that many of the ICU nurses studied were unsure about which tissues could be donated and unsure about the exact contraindications for organ or tissue donation (Collins, 2005).

In addition to the knowledge gap, nurses report that they are uncomfortable talking to families about brain death and organ donation. Nurses also report that unsupportive physicians or institutions are often barriers to organ donation, citing a hospital culture that does not encourage open dialogue among staff about donation (Lindsay, 1995; Meyer et al., 2012).
Other barriers are personal: individual unresolved personal feelings about death and our own mortality sometimes interfere with nurses’ ability to discuss organ donation with families. Finally, confusion over nursing roles in the organ donation process and a fear of intruding on the family’s grief are other obstacles to donation (Lindsay, 1995).

BREAKING DOWN THE BARRIERS

Policy

Clearly, some of the barriers mentioned above are difficult to overcome and beyond the scope of nurses. But one area where nurses have input is public policy. For nurses who make or influence public policy, changing state or federal laws to presumed-consent (opt-out) would greatly increase the supply of organs and tissues for donation. The public may support such measures, as 85% of Americans polled support organ donation. Such legislation may be necessary because, despite such support, only 28% have signed an organ donor card (Johnson & Goldstein, 2003).

The graph below demonstrates the tremendous difference in the effective consent rate in selected nations with presumed-consent (opt-out) laws (the five nations on the right) and selected nations with explicit-consent (opt-in) laws (the five nations on the left).

![Graph: Effective organ donation consent rates by country.](Source: Johnson et al., 2003.)

Obviously, legislative change such as this faces many obstacles. A less challenging strategy is to increase public awareness of the need for more organ and tissue donors.

The usual public media campaigns have done little over the years to dramatically increase the number of people willing to register as organ donors. Recently, some modifications to these campaigns have proven successful. In Michigan, officials attempted to supplement a traditional public media campaign (radio ads, bus ads, billboards) with printed materials at the point of decision (the Secretary of State offices where citizens obtain drivers licenses) and interpersonal
communication (organ recipients discussed the importance of organ donation with citizens at the Secretary of State offices). This program resulted in increases of organ donor registration of 200%–300% in each intervention county (Harrison et al., 2010), and increased the registration among African Americans by 700% above baseline (Harrison et al., 2011).

Another creative, less labor-intensive way to increase donor registration is to utilize social media. In 2012, Facebook allowed users to identify themselves as an “organ donor” on their pages and provided educational links about organ donation. On the first day of the initiative, there were 13,054 new registrations, a huge increase over the usual 616 registrations. There was an increase in registration over the next 12 days, with no concurrent increase in registration at the drivers’ licensing facilities (Cameron et al., 2013).

Nurse Education

For those nurses not involved in policy shaping, local educational efforts aimed at hospital staffs are the most effective way to remove barriers to organ and tissue donation. Many nurses feel that they need more education about donation, and this is easily remedied.

UNDERSTANDING CONTRAINDICATIONS

As discussed previously, nurses are often unsure about who qualifies for donation, and there are many myths about contraindications to donation. The reality is that few absolute contraindications to organ donation exist (Kaplow & Hardin, 2007).

- A patient with HIV or septic shock is not a candidate for donation, but patients with most other uncomplicated bacterial, viral, and fungal infections are not excluded.
- Donors with Hepatitis B or C may donate to a recipient with the same disease.
- Cytomegalovirus (CMV) is not an absolute contraindication, as the post-transplantation prophylaxis for CMV has reduced the morbidity associated with this infection.
- Cancer is usually a contraindication, except in cases of primary intracranial tumors and nonmelanoma skin cancers.
- Underlying diseases with end-organ consequences do not exclude patients: those with diabetes and hypertension may donate kidneys, and smokers with less than a 30-pack year history may donate lungs if the chest X-ray is normal.

The clear message is that very few patients are unsuitable donors, and bedside nurses should consult with the organ procurement organization if there is any doubt about a contraindication.

UNDERSTANDING THE ORGAN DONATION PROCESS

Another effective way to educate nurses is to perform simulation training. One example (Wood et al., 2012) used a patient simulator device and various clinical scenarios to help medical and
nursing staff become more familiar with the organ donation process. The scenarios enacted were meant to replicate patients arriving in the ED, then clinically deteriorating so that the staff can recognize imminent death and institute the donation pathway (i.e., contacting the OPO). At the end of training, participants all felt more comfortable and competent with the organ donation process.

For example, one scenario involved a 16-year-old with an isolated head injury and Glasgow Coma Scale of 5. The staff resuscitated the patient, got the results of the brain CT, and discussed with the neurosurgeon the poor prognosis. They then spoke to the patient’s family in the ED. The patient was transferred to the ICU and intracranial pressure monitoring was performed. Lack of response to treatment prompted the ICU staff to continue to provide updates to the family. When the neurosurgical team decided that surgery was not an option, staff instituted end-of-life care discussions. They learned that organ and tissue donation could only be considered after a decision to withdraw life-sustaining treatment has been made. The staff experienced informing the specialist nurse for organ donation, checking the organ donation register, and speaking with the family about any expressed patient wishes. They also counseled grieving family members and learned how to approach the family regarding the death and possible donation.

**DISCUSSING DONATION WITH DONORS AND FAMILIES**

Effective training sessions do not have to be that sophisticated, however. One way to increase donations is to improve ED nurses’ competency when discussing tissue donation after cardiac death. In the training sessions described in a study by Sebach & McDowell (2012), the focus was on creating meaning out of loss, how tissues can save and enhance lives, tissue processors’ roles, the role of the nurse advocate, advocate guidelines, frequently asked questions, role-playing scenarios, tough questions asked by families, and relationships with the medical examiner and funeral homes. At the end of the sessions, one-to-one training was completed for those nurses who did not feel comfortable. After the training, all nurses felt competent in discussing tissue donation, and the timeliness of tissue donation referrals from the ED increased by 87%.

**Systemic Changes**

In addition to educational programs for nurses, systematic changes in hospital procedures can help increase organ and tissue donation.

**INSTITUTING A CLINICAL PATHWAY TO IDENTIFY DONORS**

Clinical pathways that focus on identifying potential donors and instituting referrals to the appropriate organ donation specialist can improve donations. One such pathway in England (Garside et al., 2012) utilized organ donation nurse specialists in training the local staffs to identify patients with an unsurviveable condition, in which further medical treatment was deemed futile, and for whom the decision to extubate terminally had been made. The staffs were instructed to refer these patients to the embedded nurse specialists for consideration of organ donation. After using the pathway for 24 months, referrals to the organ donation team and resulting organ donations both increased.
ASSESSING INSTITUTIONAL BARRIERS

Nurses can also attempt to change the culture at the hospital to be more conducive to organ and tissue donation. One way to do this is to use the Rapid Assessment of Hospital Procurement Barriers in Donation (RAPiD), a qualitative needs-assessment tool to identify barriers to donor identification and referral (Siminoff & Marshall, 2009). A single person, from either the hospital or the local OPO, uses direct observation of hospital functions, focus-group discussions with staff, and more informal conversations with staff using a standard open-ended questionnaire. The goal is to get input from every member of the staff, including clinicians and administration.

The median time to complete the assessment ranges from 4 to 13 hours and results in a quality grade for the hospital. After the assessment is complete, formal recommendations can be provided to help the hospital improve its donation process. When first attempted, 9 of 17 hospitals improved their donation environments after using RAPiD. Some potential recommendations include:

- Allowing nurses to notify the OPO before brain death has been declared
- Educating physicians about the benefits of early involvement and collaboration with the OPO
- Standardizing the referral process rather than accepting individual physician or unit practices
- Educating nurses on technical issues

Social Support for Families

Another key component to increasing organ and tissue donation is the social support for family members of the deceased. In a study of donors vs. non-donors, researchers found that family members were more likely to consent to donation when they were given information about brain death and about organ donation that was understandable. They were also more likely to give consent when they felt the healthcare staff treated them with dignity and respected their religious or spiritual beliefs. Specifically, demonstrating understanding and compassion to the family members and providing compassionate care to the patient were key aspects of care that correlated with consent to donation (Jacoby & Jaccard, 2010).

In a study of organ procurement coordinators, two types of support were identified as significant: instrumental and emotional. **Instrumental support** included meeting the nutritional needs of the family, assisting with out-of-hospital needs, contacting religious leaders, and acting as a liaison to other family members or the healthcare team. **Emotional support** included showing sympathy, providing physical contact, allowing families to control the pace of interaction, allowing the families to speak about the deceased, expressing their own emotions, and conveying a sense of unconditional support (regardless of whether the family consented to donation or not) (Anker et al., 2013).
**CASE (concludes)**

JoAnn returns to the ED to find Jackie. She invites Jackie to see her husband one last time. Jackie pulls the sheet over her husband’s face as a final goodbye. She has read the information JoAnn gave her and asks more questions about organ and tissue donation. Jackie feels that her husband will live on in other people if his organs and tissues are donated, and she consents to the donation. JoAnn asks her if she wants to watch the organs being procured in the OR, but Jackie declines. JoAnn states that she thinks Jackie is doing what her husband wanted and offers to help her with the funeral arrangements.

**Language**

Finally, the language, both verbal and nonverbal, used by the staff requesting organ donation is critical.

- Nurses are encouraged to stop using the name of the deceased in conversation, though this can sometimes seem unfeeling to some families.
- Using the past tense when speaking about the deceased helps families understand that their loved one is indeed dead.
- Nurses should avoid euphemisms such as “passed on” or “in a better place” and use the simple “dead” to impress upon families the reality of the situation. (Monforte-Royo & Roque, 2012)

In order to help nurses deal with these situations and competently discuss difficult or technical subjects like brain death, some nursing leaders suggest role-playing to familiarize staff with the proper language (Lindsay, 1995). Such role-playing can be a part of staff orientation or part of unit in-service education.

**DISCUSSING ORGAN DONATION WITH RELATIVES OF THE DECEASED**

<table>
<thead>
<tr>
<th>What to Say</th>
<th>What Not to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The body…”</td>
<td>The person’s name</td>
</tr>
<tr>
<td>“It’s what he would have wanted.”</td>
<td>“It’s what he wants.”</td>
</tr>
<tr>
<td>“It’s what he would have liked.”</td>
<td>“It’s what he likes.”</td>
</tr>
<tr>
<td>“She died.”</td>
<td>“She passed away.”</td>
</tr>
<tr>
<td>“She’s in a better place.”</td>
<td>“She’s resting now.”</td>
</tr>
<tr>
<td>“She expired.”</td>
<td>“She expired.”</td>
</tr>
<tr>
<td>“Her organs will be donated.”</td>
<td>“Her organs will be harvested.”</td>
</tr>
<tr>
<td>Brain dead</td>
<td><em>Only</em> brain dead</td>
</tr>
<tr>
<td>Ventilator</td>
<td>Life support</td>
</tr>
</tbody>
</table>
In a comprehensive study of 1,016 requests for tissue donation, researchers found several key components to the language used in those requests. Families were more likely to consent to donation when requestors used confirmational language (expressing partnership, empathy, and understanding of the families); disclosed personal information; and didn’t interrupt the families. Requestors who were more spontaneous, less controlling, and exhibited more compassion and friendliness were more successful at obtaining consent than requestors who did not. And families consented more frequently when requestors appealed to the decision-maker’s altruistic nature or integrity (Siminoff et al., 2011).

SUMMARY

There is a definite need to increase the donation of organs and tissues from living and deceased donors. Nurses can play an active, integral part in increasing the donation rate by:

- Helping to increase awareness about the need for organ and tissue donation among colleagues, friends, and family
- Advocating for or organizing a unit- or hospital-wide formal education plan about the organ donation process and nurses’ roles in the process
- As always, providing quality, compassionate care to patients and their families at all times
- Educating themselves about the types of patients who can be donors
- Familiarizing themselves with the local protocols for in-hospital deaths (i.e. calling the OPO for every death)
- Using confirmational language when discussing organ donation with families
- Being unequivocal about what brain death means and the finality of the situation
- Remembering that nonverbal language is just as important as spoken language (appropriate physical contact, appropriate sharing of your own personal information, not interrupting families)
- Dealing with their own personal feelings about death and mortality
- Offering to help new staff members by role-playing different situations of the organ donation process
- Registering to be an organ donor
RESOURCES

Donate Life America
donatelifeline.net

Organ Procurement and Transplantation Network
optn.transplant.hrsa.gov

U.S. Department of Health and Human Services, Donate the Gift of Life website
organdonor.gov

REFERENCES


DISCLOSURE

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TEST

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1. Which organ or tissue can be partially transplanted from a living donor to a child?
   a. Spleen
   b. Heart valves
   c. Liver
   d. Cornea

2. An ICU nurse in a pediatric hospital is preparing to deliver a presentation on organ and tissue donation. Which information about minority organ donation and need does the nurse include in the presentation?
   a. Minorities are disproportionately represented on the transplant waiting list but make up a smaller percentage of organ donors.
   b. Minorities make up a small percentage of the transplant waiting list but represent a disproportionately large number of organ donors.
   c. Minorities make up a large percentage of both the transplant waiting list and the number of organ donors.
   d. Minorities make up a small percentage of both the transplant waiting list and the number of organ donors.

3. An organ procurement coordinator is speaking about organ donation to the family of a patient who is brain dead. Which information about organ donation is reviewed with the family to help them decide to donate?
   a. The family does not need to give consent in order to procure the organs.
   b. Organs can be frozen to be used at a future time.
   c. After a patient’s long illness, organs are not viable for transplantation.
   d. The procurement of organs does not mutilate the patient’s body.

4. While listening to a program on organ donation, a nursing student asks why people may not want to donate their organs. Which response by the nurse educator is not a documented barrier to organ donation?
   a. Sometimes people are superstitious that signing an organ donor card is inviting bad luck.
   b. Sometimes people are worried that organ donors will return to haunt the family.
   c. Sometimes people are disgusted by the organ procurement and donation process.
   d. Sometimes people are suspicious that healthcare providers will hasten death to procure organs.
5. Which action by a primary nurse in the ICU may help the family of a patient who is brain
dead consent to organ donation?
   a. Being the first and only person to talk to the family about organ donation.
   b. Offering the family support in attending to some of their practical human needs.
   c. Promoting organ donation in case the family member does not recover.
   d. Coordinating an immediate meeting on the unit with the OPO.

6. The nurse specialist at a university hospital is participating in an organ procurement team
   meeting. Which suggestion for increasing organ donation rates does the nurse disagree with?
   a. Enacting simulations of different stages of the organ donation process
   b. Teaching nurses to recognize the clinical triggers that identify potential donors
   c. Engaging nurses in role-play to increase their comfort and competency in discussing organ
      donation
   d. Teaching nurses to use euphemisms such as “passed away” to help the family feel more
      comfortable

7. When helping families decide about organ donation for their loved ones, members of the
   transplant team:
   a. Refer to the deceased by name.
   b. Avoid interacting in a friendly manner.
   c. Respect the personal space of family members by never touching them.
   d. Share personal stories of their own life.