End-of-life-care as a prerequisite for DCD implementation

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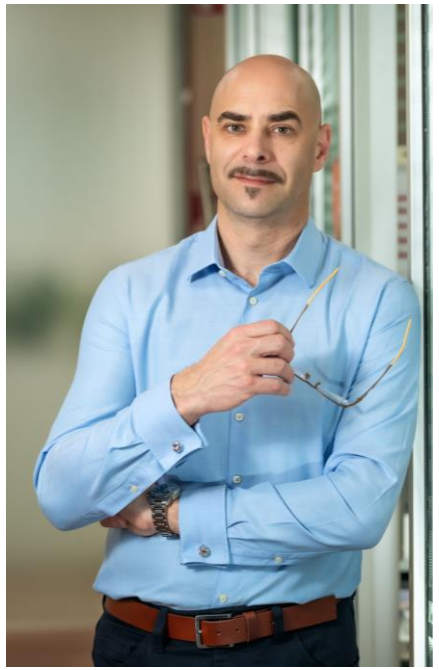
Personal data



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Disclosure of Conflicts of Interest

Nothing to declare

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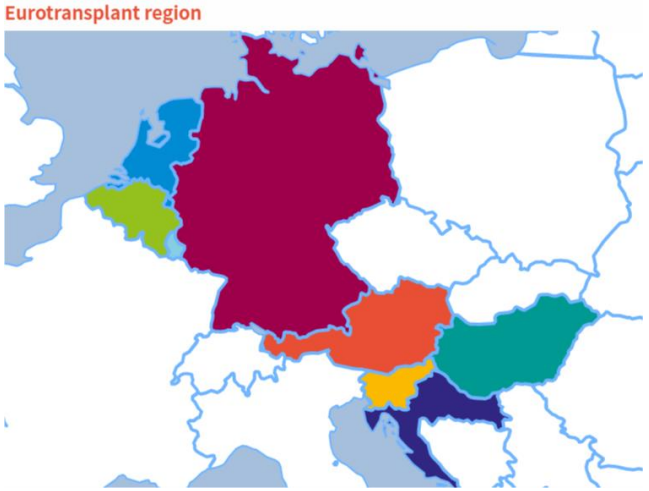
Experience from Slovenia

Slovenia - a small country in the south of Central Europe
Population > 2.124.000

An extremely good organ donation program after confirmed death:

- **Last 10 years > 22 actual donors / million population on average**
- **In 2023 > 30 active donors / million inhabitants (30,67)**
- **In 2023: the 5th country in the world regarding the number of active donors per million inhabitants & 1st country in the world with a DBD program only**

Experience from Slovenia



- **Since 2002, an equal member of Eurotransplant**

- **Several times the first in the world in terms of the number of transplanted hearts per million inhabitants**

- **We carry out heart, lung (independently since 2018), liver, pancreas, kidney and combined transplantations**

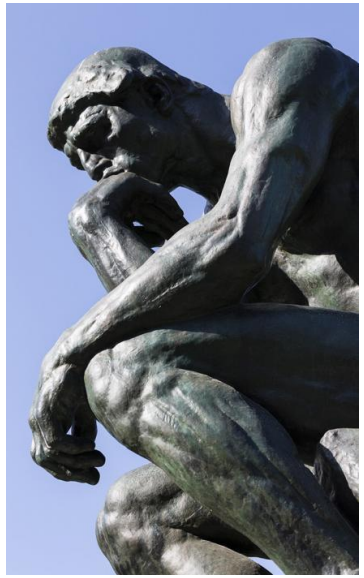
- **An effective Quality Assurance Program (QAP) for organ donation in all 11 donor hospitals**

Experience from Slovenia

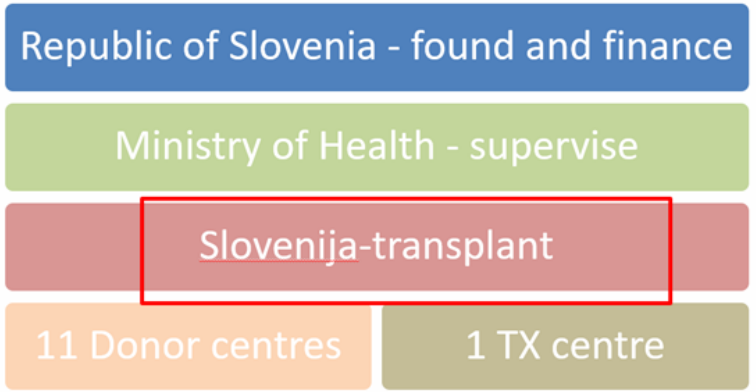
- **Before introducing DCD protocols into the domestic donor program, serious considerations are necessary, well-educated and motivated medical staff and adherence to the most verified professional findings and best practices from abroad.**

- **Slovenian donation-transplantation medicine is specific due to its closely connected professional public and relatively small size.**

- **Globally, we have a small number of donors every year (despite the high numbers calculated per million inhabitants).**



Experience from Slovenia



- **Slovenija-transplant = NCA**

- **We cannot evolve quickly and learn from our „mistakes“, which is what several bigger countries with tens of millions of inhabitants can do. Any bad news can completely stop the entire donation program.**

- **We do not accept changes quickly, among other things due to the awareness of the need for careful and unanimous changes to rules and protocols in transplantation medicine and an appropriately educated and motivated professional public.**

- **It was by searching for consensus among the professional public and through intensive training that we successfully and exemplary introduced the DBD program in the past.**

Gradual implementation of ICOD and DCD

- **We have legislation in place (first in 2000, updated in 2015) that allows organ donation both after brain death has been established and after cardiac arrest has been confirmed.**

- **At DBD, all protocols are written and this kind of donation practice has been successfully carried out for > 30 years (since 1990), and DCD protocols are being prepared.**

- **After circulatory death, only tissue donation in the morgue is possible.**

- **In Slovenia, there are currently no national guidelines that would recognize organ donation as a routine part of end-of-life care, which is why interpretations of various conflicts of interest often appear erroneously.**

- **In 2022, we started the ICOD program, but for its more effective implementation, it is necessary to update the regulations on the determination of brain death.**

Two studies on the implementation of ICOD and DCD

- **From January to April 2013 – 12 semi-structured and in-depth interviews with experts in the field of transplantation medicine (with at least 10 years of experience)**

- **Key professionals questioned the following practices at DCD:**
  1. the question of the quality of the obtained organs
  2. time after circulatory arrest until resuscitation and confirmation of death
  3. the implementation of invasive measures before death for the purpose of organ harvesting
  4. the issue of conflict of interest
  5. professional competence, motivation and consent

- **Ethical dilemmas:**
  1. the issue of violation of the deontological axiom and „the dead donor rule“
  2. confirmation of circulatory death (duration of „hands-off time“)
  3. heart transplantation after circulatory death
  4. WLST in the controlled DCD protocol

Two studies on the implementation of ICOD and DCD

- **From September to October 2021 – 10 in-depth interviews with experienced leading intensivists (6 men, 4 women) on end-of-life care decisions and donation options within c-DCD and the ICOD program**

- **Expressed dilemmas and concerns:**
  1. often the doctor decides on end-of-life procedures himself (following local rules/agreements)
  2. the autonomy of the patient is poorly expressed, the wishes of the patient at the end of life are rarely known or verified, especially consent for donation after death
  3. lack of external control mechanisms, unambiguous protocols, legislation that would also protect doctors, approvals from the ethics committee (where necessary)
  4. not only the professional, but also the general public must understand and support DCD

Familiarity with ICOD and DCD

- **Dilemmas due to insufficient knowledge of facts and results**

- **The domestic professional public is cautious, critical and reluctant to quickly introduce DCD protocols into the Slovenian organ donation program**

- **Lack of practical experience and poorly educated professional public can cause generalizations, introduce dilemmas and professional hypothetical guesses when implementing the DCD program**

Recommendations for implementing DCD

- **The decision on WLST should always be made in accordance with national guidance on end-of-life care.**
- **National end-of-life care guidance must recognize organ donation as a routine part of end-of-life care.**
- **Before the long-term implementation of DCD protocols, it is necessary to:**
  - Lay the appropriate legislative and organizational foundations
  - Adopt unambiguous and ethically acceptable professional guidelines for work
  - Educate and motivate the professional public
  - Create an appropriate broader social consensus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