The Bob and June Prickett Churchill Fellowship to study international approaches for improving tissue and organ donation experiences – Spain, USA

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Signed……………………………………    Dated……………………
INDEX

Introduction..............................................................................................................page 3
Executive Summary..........................................................................................page 4
Programme........................................................................................................page 5
Main Body..........................................................................................................page 6
  • Why travel to Spain and the United States of America?.................................page 8
  • Donation in Spain..............................................................................................page 9
    o National strategies..............................................................................................page 9
    o Regional strategies............................................................................................page 11
    o Hospital strategies.............................................................................................page 12
    o Donation after Cardiac Death........................................................................page 14
    o The Catalan Transplant Organisation.............................................................page 14
    o Transplant Procurement Management Course............................................page 15
  • Donation in the United States of America.......................................................page 16
Conclusions.........................................................................................................page 19
Recommendations..............................................................................................page 20
**INTRODUCTION**

I have been involved with organ and tissue donation for several years. Firstly I was exposed to the intricacies of organ donation when I began working in an Intensive Care Unit (ICU) and nursing potential donors. Additionally, for the last four and a half years I have also had the privilege of being more intensely involved with organ and tissue donation working as either a Regional Donor Coordinator or a State Donor Coordinator for Queenslanders Donate (Queensland Health).

For as long as organ and tissue donation has been medically possible there has always existed a large shortfall between the numbers of people who actually become donors versus the number of people on waiting lists for an organ or tissue transplant. This has been an international problem with the result that many people die every day on waiting lists around the world. I believe that all people who are stakeholders in donation and transplantation - throughout the world - should be working together to resolve this problem. Receiving the Bob and June Prickett Churchill Fellowship has given me the opportunity to observe and interact with other people working towards solutions internationally.

I will be forever grateful to the Winston Churchill Trust, and especially Mr. and Mrs. Prickett, for the opportunity that the scholarship has given me. The privilege of travelling and representing the Winston Churchill Trust has enabled me to study Spain and the United States of America’s strategies for improving organ and tissue donation experiences.

I would also like to acknowledge the two people who acted as my referees during the application process – Ms Tina Coco and Ms Michelle Foster. Without their generous words of encouragement and support I possibly would have never had this experience.

Finally I would like to dedicate this report to the amazing people I met during my travels. In particular, the staff from the Organización Nacional de Trasplantes, the Catalan Transplant Organization, the faculty of the Transplant Procurement Management course - University of Barcelona, and staff from the New York Organ Donor Network. Everyone I met was inspiring, passionate and dedicated to helping me in a way that I never expected, and the relationships that I established was one of the highlights of my Winston Churchill Fellowship.
EXECUTIVE SUMMARY

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The Bob and June Prickett Churchill Fellowship to study international approaches for improving tissue and organ donation experiences – Spain, USA.

Highlights:
• Four days at the Organización Nacional de Trasplantes, Madrid.
• One day at the Transplant Coordination Unit, Hospital Clinico San Carlos, Madrid.
• Visited the Catalan Transplant Organization, Barcelona.
• Participated in the five day Advanced International Transplant Procurement Management Course, University of Barcelona.
• One week at the New York Organ Donor Network, USA.

Recommendations:
• I fully endorse and support the Australian Federal Government’s initiative of “World’s Best Practice National Reform Agenda” and the development of the Australian Organ and Tissue Donation and Transplantation Authority. My recommendations are based on enhancing current practices in Australia, through strategies implemented overseas. National strategies that I would mention include:-
  o Continue with national guidelines and programs already established.
  o Establish and maintain nationally-consistent reporting tools (e.g. death audit data).
  o Establish and maintain nationally-consistent community awareness strategies and unify volunteers and groups to deliver consistent messages.
  o Provide nationally-consistent advertising and media campaigns using simple key messages.
  o Establish nationally-consistent legislation for donation and transplantation.
  o Establish mandated reporting for all hospital deaths to donation agencies
• Encourage community groups and volunteers with an interest in promoting donation and transplantation – providing them with training, consistent messages, and support.
• Promote and increase the number of methods available to register on the Australian Organ Donor Register, for example, the ability to Register on-line
• Support the implementation of nationally consistent clinical triggers which ensure that the option of donation is being discussed with families when appropriate. Consider setting an internationally-consistent level of documentation with regards to the donation / transplantation process.
• Consider developing a new standard to identify donor rates which accurately reflect the donor demographics in Australia, eg, donors per ICU deaths.

Implementation and Dissemination:
• Discuss experiences with colleagues and interested parties involved in donation.
• Disperse information to health workers using tools learnt at TPM course.
• Continue to promote donation with general public, media, health workers, and others.
• Encourage health professionals to continually improve their own practices
• Participate enthusiastically with the Australian National Reform Agenda.
PROGRAMME

9th – 16th November 2008
Madrid, Spain
• Four days at the Organización Nacional de Trasplantes (ONT)
• One day at the Transplant Coordination Unit, Hospital Clinico San Carlos

16th – 23rd November 2008
Barcelona, Spain
• Visited the Catalan Transplant Organization (OCATT)

24th – 28th November 2008
Barcelona, Spain
• Participated in the Advanced International Transplant Procurement Management Course, University of Barcelona

6th – 13th December 2008
New York, USA
• Three days at the New York Organ Donor Network office
• Two days at various New York Hospitals observing the Transplant Coordinator’s role
The benefits of organ and tissue donation are clear. Everyday there are people receiving life-giving and life-enhancing transplants around the world. Their personal stories are a testament to the miracle of donation and the simple words of “thank you” for their donors, and the donor families, are never felt to adequately describe the gift of life that they have received.

Sadly, there are many people who never get the opportunity to say “thank you” because they die while awaiting a transplant that never comes. Internationally, for as long as transplantation has been medically possible, there has always been a shortfall between the numbers of people who actually become donors compared to those on waiting lists.

The following graph summarises the number of deceased donors, transplant recipients, and people on waiting lists in Australia between 2002 and 2007¹.

![Number of Deceased Donors Solid Organ Transplants and Patients on the Waiting List 2002 - 2007](image)

Despite an increase in the Australian population and an increase in the general public’s awareness of organ and tissue donation, it is very sad to see the number of deceased organ donors per year has remained relatively stagnant at approximately 200 people. Statistics such as these truly highlight why more needs to be done to improve donation experiences in Australia. I know that I am not alone in voicing this opinion. My report comes at a time when much is being considered in Australia with regards to increasing our donation rates. I refer to

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the National Clinical Taskforce on Organ and Tissue Donation\textsuperscript{2}, the resulting National Reform by the Commonwealth Government in Australia (July 2008), and the Review of Organ and Tissue Donation Procedures Select Committee Legislative Assembly of Queensland (October 2008)\textsuperscript{3}.

I congratulate the Commonwealth and State Governments of Australia in recognizing that our country should be doing more to increase donation rates. The Department of Health and Ageing have stated there exists “an urgent need for a new approach” in donation\textsuperscript{4}. Their document highlights the cost of kidney transplantation and notes that typically the wait for a transplant can be many years in Australia.

\begin{quote}
"Hospital based kidney dialysis costs an average of $83,000 per person per annum. In contrast, a kidney transplant costs $65,000 per recipient for the first year, and $11,000 a year thereafter."
\end{quote}

Organ donation is certainly not limited to kidneys. If it were possible to calculate the health and economic (not to mention psychological) costs associated for all Australian’s currently on waiting lists, the resulting financial figure would be astronomical. For example, many people awaiting a heart transplant will gain extra waiting time by using Ventricular Assist Devices (VAD). According to one website the average cost of VAD support is in American Dollars $221,313 for the average time period of 9.5 months\textsuperscript{5}, not to mention the frequent hospital admissions and medical support that is routine for anyone on the heart waiting list, and the inability to work during that time.

Those awaiting liver transplantation do not have the ‘luxury’ of assist devices. End-stage liver failure can require hospitalization in Intensive Care Units, which is estimated to cost $2670 per day according to Rechner and Lipman\textsuperscript{6}. For those awaiting lung or pancreas transplantation, again the financial costs associate with medical treatments and bridging therapies are well above the resulting costs of transplantation.

\textsuperscript{2}National Clinical Taskforce on Organ and Tissue Donation. (2008). \textit{National Clinical Taskforce on Organ and Tissue Donation Final Report: Think Nationally, Act Locally, Commonwealth of Australia}
\textsuperscript{4}Department of Health and Ageing (2008) \textit{A World’s Best Practice Approach to Organ and Tissue Donation for Australia: Overview, Factsheet}
\textsuperscript{5}See http://www.cat.inist.fr/?aModele=afficheN&cpsidet=2081135
\textsuperscript{6}Rechner, I.J. & Lipman, J; (2005) \textit{The Cost of Caring for Patients in a Tertiary Referral Australian Intensive Care Unit}; The University of Queensland
All of these costs are only highlighting the cost benefit for those people who are lucky enough to receive a transplant. According to one source the “mortality rates on transplantation waiting lists are 15 to 20%”. How do we possibly put a price on the cost of lives that are lost while our donation rate stagnates?

**WHY TRAVEL TO SPAIN AND THE UNITED STATES OF AMERICA?**

When examining international organ donation rates over the last two decades, there have been three countries highlighted who have had noticeable increases in their organ donation rates.

Spain has led the world with its revolutionary “Spanish Model” - enabling an increase of 14 donors per million population (pmp) in 1989 up to 34.3 donors pmp in 2007. The United States of America (USA) have similarly raised their donor rate from approximately 20 donors pmp in 1989 to 26.6 donors pmp in 2007 using different initiatives. The third country highlighted was Italy which had closely learnt and collaborated with the “Spanish Model”. Hence my reasons for traveling to Spain and the USA were to learn from those countries who have undertaken successful strategies with regards to raising donation rates. For

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8 See [http://www.organdonation.sa.gov.au/Portals/0/NODS%201%201/20The%20Spanish%20Experience%20Matesanz%201-20pdf](http://www.organdonation.sa.gov.au/Portals/0/NODS%201%201/20The%20Spanish%20Experience%20Matesanz%201-20pdf) (slide 7)
comparison, Australia’s donation rate in 1989 was 14 donors pmp and in 2007 became 9 donors pmp.9

Of interest, whilst I was present in the Organización Nacional de Trasplantes (ONT) office, it was very quickly highlighted to me that Spain believes they can improve on their own donation rate. As this report is being written, the ONT staff are striving towards a donation rate of 40 donors pmp. They believe this rate is not only achievable and sustainable, but should be possible in other countries.

The other part of my travels incorporated participating in the Advanced International Transplant Procurement Management (TPM) Course hosted by the University of Barcelona. The course aimed to increase the quantity, quality and effectiveness of organ and tissue donation to assist the participant’s local community.10

DONATION IN SPAIN

Much has been written in the past with regards to the Spanish Model. I am well aware that the Government’s recent studies have explored the Spanish system and have included the involvement of Dr Rafael Matesanz, Director of ONT, in many past National and State Summits and taskforces in Australia. Therefore I shall not re-state what has already been well defined and discussed in the past. I shall rather comment on my first-hand experiences that were gained as a result of the Winston Churchill Fellowship.

NATIONAL STRATEGIES

The Spanish model can be easily divided into national, regional and hospital strategies for improving donation experiences. Since my first week abroad was based in the central office of ONT, I was able to very clearly observe the impact of having one national institution able to coordinate the entire country. I believe the strength and advantages of ONT’s presence has been to encourage cohesive collaboration between all stakeholders of organ and tissue donation in their country. Dr Matesanz has described the one central office as “the support agency in charge of organ sharing, transport, waiting list management, transplant registries,

10 See http:www.tpm.org/
statistics, general and specialized information and action which can improve the whole process”11. I believe Australia can learn from the experiences of a country which has proven to increase donation rates under a national coordination approach.

The National Clinical Taskforce on Organ and Tissue Donation 12 made their first recommendation “A new national approach and system: A national authority and network of organ procurement organizations”, so I certainly do not stand alone with this opinion. I understand that the history of our present autonomous State-based donation agencies has evolved from a system of different state-wide legislations, health-care systems, funding and unique geographical considerations. Whilst Lindsay highlights “there may be strength in diversity, attempts to implement national programs...are guaranteed to be prolonged, frustrating and frequently acrimonious.”13

I have been employed by one of these state-based agencies for some time and truly believe they have been responsible for implementing some innovative projects and strategies to raise donation rates (one example is the development of an on-line General Practitioner Resource Kit in 2008). However, after being present in Spain’s ONT office I have seen how much more powerful the presence of a national organization can be. All regions and interested stake-holders are very much working together cohesively to achieve goals.

A simple example of this is in the reporting of death audits in hospitals. In Spain, all Transplant Coordinators use a nationally consistent reporting system; however the same cannot be said for Australia. An additional example is that any media enquiries are handled by the ONT. This enabled an easy resource for media professionals, the development of positive relationships with key people, and consistent information (by trained staff) being dispersed.

In Australia we also have other interested stake-holders involved with donation and transplantation that may benefit by a more unified national approach. There are multiple organizations and groups in the community that have an interest in this field. For example,

11 See http://www.uktransplant.org.uk/ukt/newsroom/bulletin/current_bulletin/organ_donation
there are groups that are specifically for transplant recipients or people with serious organ
diseases (such as Kidney Health Australia). We also have groups like Transplant Australia
and the David Hookes Foundation who are interested in promoting donation awareness.
Other organizations include the Lions and Rotary Clubs who at various times in the past have
offered their support and assistance with raising donation awareness, not to mention the
individuals who have been affected by donation or transplantation in a personal manner and
offer their help. Whilst all these people have done incredible work in helping with donation or
transplantation issues in their own individual ways, I consider what sort of an effect there may
be if everyone in this group worked towards nationally-consistent goals.

Whilst I have highlighted the inconsistent aspects of donation in Australia I would like to
make mention of three very important nation-wide aspects. Firstly, there exists the Australian
and New Zealand Statement on Death and Organ Donation\textsuperscript{14}. This document is used
throughout our country and ensures consistent information and guidelines are used in the
practical process of donation in the setting of Intensive Care Units. I gained a renewed
appreciation of this document after my experiences in the USA where such a document is not
used. Another consistency we have in Australia is the Australasian Transplant Coordinators
Association (ATCA)\textsuperscript{15}. ATCA (among other activities) have played an enormous role in
enabling nationally consistent practices between the states of Australia and New Zealand.
Finally, the third nation-wide program I would like to mention is the Australasian Donor
Awareness Program for Transplantation (ADAPT) which aims to educate health
professionals involved with organ donation in the critical care setting\textsuperscript{16}. I discovered while I
was at ONT that they run a very similar program in Spain with similarly great feedback from
participants.

\textbf{REGIONAL STRATEGIES}

Where the Spanish Model has three differing levels of donation (national, regional and
hospital) the same cannot be said for Australia. For example in Queensland there are
predominantly two levels - the state-based agency \textit{Queenslanders Donate} which most

\textsuperscript{14} Australian and New Zealand Intensive Care Society (2008). \textit{The ANZICS Statement on Death and Organ Donation (3\textsuperscript{rd}
Edition).} Melbourne, ANZICS

\textsuperscript{15} Australasian Transplant coordinators Association Incorporated (2006). \textit{National Guidelines or Organ and Tissue
Donation, 3\textsuperscript{rd} Edition}

\textsuperscript{16} See \url{http://www.adapt.asn.au/}
closely meets elements of the national and regional level in Spain; and the Regional Donor Coordinators – whose role would more closely match the hospital level in Spain.

Since the Spanish Model has been closely studied in the past, it has been elements of the Regional level which have been most adopted in various state-based agencies in Australia.

“The South Australian Organ Donation Agency has adopted the most Spanish Model strategies in their own practice and have consistently shown the highest donation rates in our country every year”\(^\text{17}\).

At the Regional level in Spain I learnt that some of the key responsibilities are to offer support for the Transplant Coordinators in the hospitals, provide ongoing support with donation families, and the overseeing of data collection and death audit information in their regions. Other aspects involved external auditing of other regional areas with a goal of continual improvement, the management of any logistical issues in their own area, and the management of volunteers who undertake community education and awareness activities.

**HOSPITAL STRATEGIES**

Dr Matesanz has often credited the implementation of hospital-based Transplant Coordinators as a large component of why the Spanish Model has been so successful\(^\text{18}\). Whilst my own role as a Regional Donor Coordinator would be the most similar to the Spanish Transplant Coordinator role, our working days are spent very differently. The similarities begin with both being based within hospitals that have intensive care units and more hours / resources allocated to those hospitals with Intensive Care Units and Neurotrauma facilities. We also play similar roles with regards to the actual process of organ donation within our intensive care units – for example, undertaking documentation such as consent and the patient’s history, donor management, and organizing local logistical issues in our hospital. Another similarity is the collection of death audit data and the support given to other health professionals involved in the process of donation.

\(^\text{17}\) Lindsay, B (2001) *Translation of the Spanish model to Australia: pros and cons* Nefrologia, Vol XXI, Suplemento 4, 2001

I believe the greatest disparity between our jobs is in the numbers of organ donors that Spain has in comparison to Australia. When you consider that Spain’s population is approximately 40 million with a donor rate of 34.3 donors pmp, the number of organ donors that a Transplant Coordinator is involved with forms a very significant proportion of their time. The remainder of their role is spent in follow up of donor families, death audits in their own hospital, and educating their fellow health professionals.

In comparison Australia’s population of approximately 20 million and a donor rate of 9 donors pmp (in 2007) means that only a small proportion of my time is spent actually participating in organ donation cases. The majority of my role as Regional Donor Coordinator involves activities which aim to increase the general public’s awareness of donation (such as talking to community groups and high school children and working with my local media contacts), as well as educating health professionals and performing death audits for my region.

I believe a major cause of the difference in organ donor numbers between Spain and Australia at the hospital level is the way our patients are medically treated. In both countries it is regular practice that when a patient is received in the Emergency Department with some form of head trauma they are quickly stabilised, and a Computerised Axial Tomography (CAT) Scan is performed of the patient’s head to assess the problem. The CAT scan is then assessed by specialized doctors to determine the patient’s treatment. In Spain, regardless of the CAT scan results, all patients are treated and admitted into an intensive care unit where donation becomes a possibility if death occurs.

In Australia the course of events may be quite different. Once the CAT scan is reviewed by specialists, if it is deemed that the head injury is not conducive to any form of meaningful recovery, or not compatible with life, then after consultation with family members, the patient will have treatment withdrawn. The patient is made comfortable and will die in circumstances that mean they are not medically suitable to become organ donors. The doctors involved in these cases feel quite strongly that any form of further treatment for these patients is ethically, morally and legally wrong (per the Health Services Act (Queensland, 1991)). I have been told many times in my working life that they believe admission to an intensive care unit (where the patient may potentially become an organ donor) is not in the patient’s best interests.
Interestingly, when I mentioned this happens in Australia to my colleagues in Spain, they were truly amazed that our cultures could be so different. Never-the-less this difference makes the number of potential organ donors in Australia quite diminished in comparison with Spain.

DONATION AFTER CARDIAC DEATH (DCD)

During my first week in Spain I was fortunate to spend one day at the Transplant Coordination Unit, Hospital Clinico San Carlos, Madrid. As soon as I walked in the door of the Clinic I was told the staff were expecting a patient to arrive in the next twenty minutes who could be a potential DCD donor. The patient was someone who had collapsed in the streets of the city with a suspected heart attack and resuscitation attempts had been unsuccessful. I was able to observe the entire process of this donor from their arrival by ambulance and police escort into the Emergency Department, through to the operating theatre where I watched two perfect kidneys being established on perfusion machines awaiting their new recipients. I have since spoken with several of my colleagues about this experience and I was able to describe how much dignity and respect was shown to the patient and their family. I was also pleasantly surprised at how positive and proud all the hospital staff were about this patient becoming a donor.

Whilst DCD does occur in Australia, there are some fundamental reasons why the number of DCD donors cannot compare with the number of DCD donors in Spain. Spain practices Maastricht Category I and II, which means that donation occurs in the “uncontrolled” setting, i.e., death has usually occurred outside of the hospital. This is in line with their legislation and accepted within their culture. However in Australia, Category I and II is not legally permissible. Instead, we practice Category III and IV, which is within our legislation and in the “controlled” environment of the Intensive Care Unit. Whilst I am aware of the counter arguments for the different Maastrict Categories, comparatively speaking, the potential for organ donation in the uncontrolled setting appears to be greater than in the controlled setting.

THE CATALAN TRANSPLANT ORGANIZATION (OCATT)

During my time at OCATT, I discovered that the office generally worked in the Spanish organ donation network at the Regional Level for the area of Barcelona. However, an important
anomaly is that OCATT is also the office given the responsibility of liaising with Eurotransplant (the organ allocation centre) with regards to organ sharing and allocation. As a brief overview, the organs from each donor will firstly be offered to patient’s on the waiting list in their own particular country. For various reasons, the organs may be offered to other countries. At OCATT I was able to observe Spain’s involvement with this area of donation and transplantation.

Australia presently has an fair and effective organ allocation system. Agreements with New Zealand are also included in Australia with regards to organ sharing and allocation. Logistical and geographical considerations are important aspects of allocation in Australia which are not a major consideration in Europe where travelling times between countries is so much shorter. Whilst it was very eye-opening and interesting for me to learn about some of the logistics involved with sharing organs between the different countries in Europe, I don't believe there were any aspects that could be adopted by Australia to improve our donation / transplantation allocation processes.

There was only one particular feature of the organ sharing process which varied widely between our countries which I found very interesting. In Spain all offers of potential organ donors are made using one double-sided A4 sheet paper with the donor information. In Australia we use a booklet which contains 21 pages (18 being information and three being blank note pages at the back) which takes a great deal of time and effort to complete thoroughly. The difference in the collection of data certainly opened my eyes to the lack of international standards with regards to what is considered important information during the donation / transplantation process.

TRANSPLANT PROCUREMENT MANAGEMENT COURSE

An absolute highlight of my travels during the Winston Churchill Fellowship was the ability to participate in the one-week intensive Advanced International Transplant Procurement Management (TPM) Course, University of Barcelona. I would highly recommend this course to all health professionals with an involvement in organ donation and transplantation. The course walked the participants through the various stages of donation using didactic teaching in the class-room mixed with practical “work stations” and interactive games. I gained more of an appreciation of international issues related to this field, as collaboration and information
sharing was encouraged between the participants from 23 different countries. I also found renewed enthusiasm and pride for the work that I am involved in, and am looking forward to educating my colleagues in the work-place using a variety of different tools and exercises that they certainly won’t be expecting!

**DONATION IN THE UNITED STATES OF AMERICA (USA)**

The USA has been credited with much of its success in raising donation rates with The United States Organ Donor Breakthrough Collaborative. The following graph illustrates the impact the Collaborative had in the USA between the years 1999 and 2006.

As with the “Spanish Model”, much has been written about the USA Collaborative effort. Therefore I shall only highlight my personal exposure and experiences whilst representing the Winston Churchill Fellowship.

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19 See: http:www//Donate_Life_2006
20 See: http:www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/.../OrganDonationBreakthroughCollaborative.htm
I admit my first impression of the New York Organ Donor Network (NYODN) was imposing, very professional and a little intimidating. The office was established in a beautiful high-rise in Manhattan, New York City – complete with approximately 150 staff, computers and telecommunication systems I had only ever seen in movies, and efficient departments going about their business. From a company of this size, the Agency was able to sustain positions such as a Chief Executive Officer, Chief Financial Officer, Project Manager, Quality Assurance Managers, Clinical Managers, Volunteer Services Manager, Media and Community Project Managers to name a few. I found this to be a vast difference to what I was personally used to - where the entire staff involved with Queenslanders Donate is only a handful of ‘multi-skilled’ people.

Of course the difference in staffing is comparable with the difference in organ donor numbers. The NYODN had 755 organ donors in 2007\textsuperscript{21} compared with Australia (with a similar population) managing 259 donors in that same time\textsuperscript{22}.

The other obvious difference for me was that the agency is very autonomous and separate to any one particular hospital. One of my first questions to the clinical staff was about how they become aware of any potential organ donors if they are not physically in the hospitals. It was explained to me that Federal and local regulations mandated that every death and every imminent death be reported to the local organ procurement organization. For example, the NYODN had several laws which impacted on their relationship with hospitals in the area:-

- Uniform Anatomical Gift Act of 1968,
- Uniform Determination of Death Act,
- National Organ Transplantation Act of 1984,
- New York State Required Request Act of 1986,
- Omnibus Budget Reconciliation Act of 1986,
- New York State Required Referral Law of 1998, and
- Conditions of Participation (to receive Medicare funds) – HCFA Regulation of 1998.

Hence, many resources at NYODN were directed towards establishing and maintaining successful, working partnerships with the hospitals in their area. Regular issues that arose

\textsuperscript{21} See: http://www/optn.org
\textsuperscript{22} Australia and New Zealand Organ Donation Registry (2008). ANZOD Registry Report 2008, Adelaide, South Australia
were hospitals referring patients without adequate patient information, referring patients too early or too late, or with little regard for the “clinical triggers”, or guidelines that NYODN had stipulated. Once a hospital appeared to have a potential organ donor then a Transplant Coordinator would personally attend the hospital to review the patient and manage the process of donation.

A very surprising aspect which I discovered was the typical process for organ donation in the hospital. As with Spain, all patients with severe neurotrauma were treated (regardless of perceived outcome). What I discovered at NYODN though, was the extended amount of time it could take for a patient to be declared brain dead and move through the process of donation. Every hospital had its own policy and procedure guidelines for the procedure of declaring brain death – some hospitals expected observation periods of up to 48 hours for this task (in comparison to Australia, where observation periods have a minimum time of at least 6 hours\(^{23}\)). In some of the smaller New York hospitals, simple diagnostic tests such as liver biopsies or cardiac echocardiograms were simply not available outside business hours or weekends and would result in potential organ donors being maintained in the Intensive Care Unit for days. If a family had difficulties understanding or accepting brain death, then similarly, the patient was maintained in the Intensive Care Unit until the family could accept the diagnosis. This was an interesting experience for me, as I was more used to working in conditions where there is an intense pressure for intensive care beds. I am not aware of a brain dead patient being maintained in an intensive care unit for days awaiting procedures or family acceptance of the situation in Australia.

It was also very interesting to compare the difference in patient care with regards to the intensive care units. I am very used to the “intensivist model”\(^{24}\) of care used in Australia whereby all patients in the ICU are managed by doctors who specialize in ICU medicine. In comparison, the majority of patients in the USA will remain under the management of their original doctor regardless of an ICU admission (for example, may be managed by a neurosurgeon if their original problem required neurosurgery). Therefore, the staff in the USA ICU departments needed to deal with multiple different doctors with different specialties.


(sometimes for the same patient). This of course, added to the challenges faced by the donor coordinators from NYODN.

As with Spain, I learnt that in the USA, community volunteers were utilized for community education and awareness campaigns.

CONCLUSION

The Bob and June Prickett Churchill Fellowship has given me the experience of a lifetime. I feel absolutely privileged and honored to have undertaken travel that I would have otherwise never done. I have learnt so much from my first-hand experiences and from collaborating with international health care workers who are passionate and enthusiastic about donation and transplantation. I have without-a-doubt gained an appreciation of international approaches towards organ and tissue donation that would never have been possible without the Winston Churchill Fellowship.

As mentioned earlier in this report, this opportunity came about during a time of great interest in raising Australia’s donation rates by Federal and State governments. I certainly hope my report will give another perspective about the donation process that will stimulate change and growth in this area.
RECOMMENDATIONS

• I fully endorse and support the Australian Federal Government’s initiative of “World’s Best Practice National Reform Agenda” and the development of the Australian Organ and Tissue Donation and Transplantation Authority. My recommendations are based on enhancing current practices in Australia, through strategies implemented overseas. National strategies that I would mention include:-
  o Continue with national guidelines and programs already established.
  o Establish and maintain nationally-consistent reporting tools (e.g. death audit data).
  o Establish and maintain nationally-consistent community awareness strategies and unify volunteers and groups to deliver consistent messages.
  o Provide nationally-consistent advertising and media campaigns using simple key messages.
  o Establish nationally-consistent legislation for donation and transplantation.
  o Establish mandated reporting for all hospital deaths to donation agencies.

• Encourage community groups and volunteers with an interest in promoting donation and transplantation – providing them with training, consistent messages, and support.

• Promote and increase the number of methods available to register on the Australian Organ Donor Register, for example, the ability to Register on-line.

• Support the implementation of nationally consistent clinical triggers which ensure that the option of donation is being discussed with families when appropriate. Consider setting an internationally-consistent level of documentation with regards to the donation / transplantation process.

• Consider developing a new standard to identify donor rates which accurately reflect the donor demographics in Australia, eg, donors per ICU deaths.