UKDEC
UK Donation Ethics Committee

Extubation

An application of *Interventions before death to optimise donor organ quality and improve transplant outcomes: guidance from the UK Donation Ethics Committee*

In the document *"Interventions before death to optimise donor organ quality and improve transplant outcomes: guidance from the UK Donation Ethics Committee"* UKDEC published guidance designed to assist clinicians by providing a more detailed account of the generic balancing process that clinicians may need to follow. This paper applies that generic guidance to the specific question as to whether it is appropriate to extubate a potential DCD donor.

Unlike other interventions to optimise donor organ quality and improve transplant outcomes before death, extubation may be considered earlier, after

(1) it has been decided that the continuation of life-sustaining treatment is no longer in the best interests of the patient.

Extubation is an acceptable form of treatment withdrawal, regardless of whether

(2) it has been decided that organ donation would be in the best interests of the patient.

There is anecdotal evidence that the prevailing view, held by many clinicians, is that extubation will lead to a more rapid time from withdrawal of treatment to death than leaving the endotracheal tube in. To date, there has been no published evidence to support this view. The limited evidence which does exist suggests extubation makes no difference to the time from withdrawal of treatment to death.

Despite this the view persists and anecdotal evidence suggests that extubation is more common where donation is planned, but used less frequently where it is not. Further studies are in development to improve the evidence on this

point. Extubation is, however, still an acceptable method of treatment withdrawal as discussed below.

In determining whether extubation is an appropriate part of treatment withdrawal, the clinician should take into account and consider the family's view about whether extubation is in the best interests of the potential donor. In the absence of firm evidence as to the effect of extubation on the time from treatment withdrawal to death by circulatory criteria, and hence its effect on the quality of the organs, the clinical team need to determine with the family whether extubation is appropriate.

Factors to consider may include:

> Withdrawing the ET tube enables the family to see the face of their loved one;
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> Some potentially distressing symptoms (choking and gasping) may occur. Although these symptoms should be anticipated and can usually be managed by pharmacological interventions, and patient positioning to optimise the airway, they may be distressing to both family members and staff.

It is possible that this precursor decision ((1)) may need to be revisited, for example if the patient's condition improves so that continuation of life-sustaining treatment would now be in their best interests or is no longer needed.

Whatever the method of treatment withdrawal, the potential donor should always receive comfort care measures to alleviate any pain or distress. Patients, regardless of whether they may be potential organ donors, are entitled to and, where appropriate, should receive, treatment to alleviate pain and distress following any withdrawal of life sustaining treatment. This would include treatment to alleviate pain and distress following extubation. A clinical decision not to administer appropriate treatment to alleviate pain and distress following extubation which is based upon a concern that to do so would hasten death is misplaced. We consider that not providing appropriate

relief for pain and distress to a patient following withdrawal of treatment is not acceptable.