

# Honoring the registry: REALLY!

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- Decision tree sparked conversation
- Decision to not allow Lifeline to go to the OR without family approval
- Several meetings ensued with Lifeline and Hospital council
- Agreed if this were to happen hospital would need Lifeline to obtain a court order to proceed

- Referral made on July 3<sup>rd</sup>
  - 21yr-old AA Male hit and run while riding a bike at 4am
- Media heavily involved from beginning: family interviews started immediately
- Lifeline on site and aware family struggling
- Declared BD on July 4<sup>th</sup>: Family refusing to accept diagnosis
- Lifeline proceeding with donation management family aware

- On July 5<sup>th</sup> at 4pm ready to go to the OR 6 organs placed
- Family still unaccepting of BD diagnosis
- Administration from Lifeline and Hospital involved
- Agreed to let family have time to further understand BD diagnosis-family wanting testing repeated the next day



- BD assessment repeated in front of family, flow study done and reviewed with family
- Hospital remained committed to not allowing Lifeline to go to the OR without family permission
- July 7 situation remained the same family not accepting, hospital continuing to block OR

- Monday July 8<sup>th</sup> 9am large meeting convened to discuss plans
- All agreed that Lifeline would proceed as previously discussed and get a court order, all amenable
- On July 9<sup>th</sup> decision made to have one final conversation with the family by Lifeline Administration – family refused
- Paperwork prepared to be filed in the morning

- 10am on July 10 (Brain death 6 days prior) a request for declaratory judgment naming the family and Hospital, request allowing donation to proceed
- Judge's first wife a heart recipient
- Family did not show in court, hospital did
- Judge ruling was clear and concise – it's legally binding hospital and family are to step aside
- Meeting at the hospital at 1pm to plan next steps



- Family left hospital without incident at 5:15
- Allocation had to be done again
  - Heart team backed out for fear of media backlash
  - Liver patient died while waiting
- Donor became unstable at midnight
- On July 11<sup>th</sup> (7 days after brain death) went to the OR at 2am



- Liver, kidney/pancreas, kidney recovered and transplanted
- Liver slow to perfuse and ultimately re-listed and died on July 12<sup>th</sup>
- k/p and kidney patients doing well



- Multiple news reports on the issue
- For the most part empathetic to the family, but clear that the decision to donate rested with the deceased
- Overwhelming support on social media with a few exceptions
- Long term effects unknown

- Having had the discussion with our hospitals allowed us to know where this was going to go
- Being clear and steadfast on our decision
- Board Support/CEO support
- A fully developed legal and media plan prior to the event

- Working with the hospital leadership to mend fences and create a plan for “next time”
- Dealing with hospital anger
- CEO meeting with hospital for in house coordinator plan



WILL WE DO IT AGAIN?



Yes!