Requesting for Anatomical Donation
in Hospital Settings:
A Descriptive Study

by

Karen A. Suchowski, R.N., B.S.N.

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APPROVED:

[redacted]

Caroline M. White, R.N., Dr.P.H., Professor
Department of Community Health Care Systems
Research Project Advisor

[redacted]

Jane M. Kirschling, R.N., D.N.Sc., Associate Professor
Department of Family Nursing

[redacted]

Stella J. Logan, R.N., M.S.N., Assistant Professor
Department of Mental Health Nursing
Mental Health Clinical Nurse Specialist
Oregon Health Sciences University

Ba[redacted]D., Associate Professor
Department of Community Health Care Systems

[redacted]

Carol A. Lindeman, R.N., Ph.D., F.A.A.N., Dean
School of Nursing

TABLE OF CONTENTS

Appendices

LIST OF FIGURES

Chapter I

Introduction

The purpose of this research project was to describe how the next of kin are asked about the anatomical donation of a deceased relative when the death occurs in a hospital and to determine the effect of specific variables on the requesting process. Much attention has been focused recently on organ transplantation and the shortage in the supply of organ for transplantation (Englehardt, 1984; Gunby, 1984; Inglehart, 1984). According to the report of the Task Force for Organ Transplantation sponsored by the U. S. Department of Health and Human Services (1986), nearly 10,000 people are waiting for kidneys, 300 people are waiting for livers, 450 people are waiting for hearts, and 91 people are waiting for heart-lung transplants.

The increased success of transplantation procedures has widened the gap between the demand for organs and the number obtained for use (Inglehart, 1983; Kolata, 1983; Van Theil & Starzl, 1983). The use of immunosuppressive drugs such as cyclosporine, better tissue-matching capabilities and improved surgical techniques have contributed to the improved survival rates of transplant recipients (Caplan, 1984).

In 1985, states began passing laws to ensure that hospital personnel ask the next of kin about anatomical donation when the deceased has not indicated any written information or voiced any opinion on or opposition to donation. In Oregon, this law is known as routine inquiry. Oregon was the first state to pass a law requiring hospital personnel to ask the next of kin about anatomical donation, and approximately 30 states now have a similar law.

Hospitals have implemented policies and procedures to comply with the requirements of the routine inquiry law. Data collected by the Oregon State Health Division indicates that 24,362 deaths occurred in Oregon in 1987, and that approximately 42% (10,366 deaths) occurred in hospitals. Routine inquiry in hospital settings encourages the next of kin to consider donating the organs of a deceased family member. This alternative may not be considered until a request is made by hospital personnel.

The Oregon law regarding routine inquiry as implemented by the Oregon State Health Division requires that hospitals comply with the following administrative rules: Request for Tissues and Organs - ORS 333-72-100; Training for Requestors - ORS 333-72-

105; and Hospital Compliance - ORS 333-72-110. A copy of the rules is located in Appendix A.

Request for Tissues and Organs, ORS 333-72-100, requires that, when a death occurs in the hospital, the hospital administrator or designated representative shall request the next of kin to consent to donating all or any part of the deceased's body as an anatomical gift. This rule was written to ensure that hospital staff would notify one of the hospital's designated requestors at the occurrence of each death in the hospital, and the next of kin always be given the opportunity to donate organs if the deceased is an eligible donor according to established medical criteria. However, per ORS 333-72-100 (1) there are circumstances in which a request is not required. This rule allows the physician and the requestor to use personal judgment about which individuals should be requested for donation.

Even in instances where the deceased fulfills the donor criteria for certain anatomical donations, the request may not be made. In some instances, the requestor may only be contacted after receiving permission from the deceased's physician; therefore, a request may not be made because of the physician's wishes. In other circumstances, the designated requestor for the hospital may decide that requesting for organ donation would induce too much distress upon the next of kin and not make a request.

ORS 333-72-105 (1) states that all persons making requests for donations shall have received training in accordance with the rule, and ORS 333-72-105 (2) lists the content which should be included in the training program. This rule allows that a hospital may vary in the selection and training of its designated requestors. For example, differences in criteria for selection of requestors exist. Some hospitals chose nursing supervisors as their designated requestors. Other hospitals chose chaplains as their designated requestors. Policies and procedures also vary between hospitals though administrative rules of the routine inquiry law have been satisfied by the hospital.

More information was needed to determine how the process of routine inquiry is practiced in hospital settings. This information could be used to identify difficulties that requestors experience when performing routine inquiry. In addition, information describing routine inquiry practice would help identify variables that assist requestors in achieving their objective, to provide the next of kin with an opportunity to donate in a unpressured and emotionally supportive environment.

Review of Literature

The literature reviewed includes a review and critique of reports of research on anatomical donation, articles on the social dimensions of anatomical donation, and articles from health professionals about their experiences with requesting for anatomical donation. Medical and nursing literature from 1979 to 1988 was examined. The medical literature focuses strongly on the physiological maintenance of the potential donor and the transplant process. The nursing literature includes the most information about the requesting process. Articles selected for discussion are those that examine why an identified potential donor does not become an actual donor and those that describe the requestor's and the potential donor's family members' feelings and opinions about routine inquiry.

Bart and his colleagues (1981) identified several reasons why an identified potential donor does not become an actual donor. This study examined the medical records of 555 in-hospital deaths in 37 acute care hospitals in northern Georgia. Requesting and procurement processes were defined for each hospital:

1) how and by whom donors were identified and 2) procedures for declaration of death, consent, and communication between the hospital and the transplant team. The physicians and nurses responsible for the care of each potential donor identified by the medical review who did not become an actual donor were interviewed by the researchers to better understand the reason the potential donor did not become an actual donor. To identify the factors contributing to successful procedures, those persons involved in the care of each potential donor who became an actual donor were also interviewed.

Of the total deaths within the 37 hospitals, 229 potential kidney donors were identified, of whom 15% actually became donors. Bart and his colleagues cited the following reasons for an identified potential donor not becoming an actual donor after the referral was made to the procurement staff: limited donor management skills of the hospital or staff, instability of the donor, delay in the declaration of death, the inability to obtain consent from the next of kin, the unavailability of a surgeon to perform the procurement, and a delay in obtaining an operating room.

After referral, obtaining a consent for organ donation was identified as the next most important step in the procurement process (Bart et al., 1981). It was also determined that the duration of time from the onset of illness to the death was frequently an inhibiting factor in obtaining a consent, and a rapid clinical course progressing to death was associated with more frequent refusals of consent. In addition to identifying the reasons a potential donor does not become a donor, the study provided quantitative data to describe the contributing factors that affect each reason. Though the study was highly credible, because the data were limited to kidney donors, the results cannot be generalized to all donors. Other studies have identified the importance of health professionals' perceptions of anatomical donation of the requesting process.

Sophie, Salloway, Sorock, Volek, and Merkel (1983) used qualitative and quantitative methodology in a two phase study to identify intensive care nurses' perceptions of organ procurement. Phase I used participant observation to describe 10 hospital donor calls. Field notes were recorded and analyzed for themes. In-depth interviews were then conducted with 12 organ procurement coordinators who resided in six different geographical locations to identify their perceptions of hospital operating procedures and intensive care nurses' roles in organ procurement. Individuals active in the requesting and procurement process were identified from this phase. They included intensive care nurses, attending physicians, and the potential donor's family members.

In phase II, a questionnaire was distributed to 560 intensive care nurses employed in 27 hospitals in Illinois and Indiana. Three hundred and twelve nurses responded to the questionnaire. The survey consisted of open and closed-ended questions regarding nurses' knowledge of donor criteria. Information was obtained to identify nurses' perceptions about the roles of other professionals active in the requesting and procurement process by having the nurses identify who was first to recognize potential donors (physician or nurse), and who requested the next of kin for donation. Nurses' personal attitudes toward anatomical donation and their perceptions of the request on the donor family members' emotional status were also examined.

The results of the survey indicated that nurses where highly aware of the medical criteria for donor eligibility. Sixty-three percent of the nurses indicated that it is a nurse who first identifies the patient as a donor and 31% indicated that a physician who first recognizes the donor. Seventy-nine percent indicated that the approach to the family is made by the physician and 17% percent indicated that the approach is done by a nurse. Eighty-six percent approved of organ donation. Twenty-five percent described participation in the care of a potential organ donor as a rewarding experience. However, 21% found participation in the care of the potential donor to be emotionally draining, and they reported experiencing ambivalent feelings toward the maintenance of the donor. Twelve percent expressed concern about the stress that may be placed upon the family when the family is asked about donation.

The study of Sophie, et al. (1983) is important because it used quantitative methodology to examine nurses' attitudes toward anatomical donation. Because of an overall response rate of 55% and varying response rates to different questions, the results cannot be generalized to all nurses. However, the results indicated that ambivalent feelings toward organ donation exist among intensive care nurses. Furthermore, the attitudes of health professionals may influence their decision to request the next of kin for donation (Stark, Reiley, Osiecki, & Cook, 1984).

A pilot study by Stark, et al. (1984) described the attitudes toward organ donation in an intensive care unit. A seven-item questionnaire was completed by intensive care nurses each time a potential donor presented in an intensive care unit (N=26). The questionnaire identified when and by whom the donor was recognized, the general attitudes of family, nurses and physicians, and if applicable, why donations did not occur. Data were collected over one calendar year.

Fourteen patients (54%) were recognized as potential kidney donors upon their admission to intensive care. The nurse was the first person to recognize the patient as a potential donor in 11 cases (42%), the physician in 9 cases (35%), and the physician and the nurse concomitantly in 6 cases (23%). Of the 8 donations that did occur, analysis of physician and nurse attitudes revealed that 8 nurses and 7 physicians favored the general concept of anatomical donation.

The findings of Stark, et al. indicate that issues between the time of donor identification and the decision of next of kin to donate may prevent a donation. Of the 18 donations that did not take place, physiologic reasons were cited in 7 cases, the physician's fear of litigation was cited in 6 cases, and the physician's assessment that the family would not be agreeable or able to cope with the thought of donation was cited in two cases. The remaining three potential donations did not take place because of family reluctance. And of these, the uncertainty of the family regarding the concept of brain death precluded donation in 2 cases. The period of time from donor identification and the decision of the next of kin to donate could be a significant point of intervention by hospital personnel.

The results of a much larger study of the attitudes of health professionals and hospital administrators toward organ donation conducted by Prottas and Batten (1988) indicates that ambivalent feelings about the concept still exist. A random sample of neurosurgeons (n=246) were surveyed by mail with a questionnaire of 50 items, and intensive care unit nurses (n=878), hospital administrators (n=222), and directors of nursing in the United States (n=227) were surveyed by mail with a questionnaire of 90 items to identify their attitudes and opinions about organ donation. Respondents answered a Likert type questionnaire using a scale of "strongly agree" to "strongly disagree". Analysis of the results indicated that greater than 90% of each group surveyed supported organ donation. However, the results also indicated that there was general agreement among all surveyed that organ donation processes in the hospital setting place heavy emotional demands on all professionals involved, and that physicians are especially hesitant to approach donor families.

More specifically, two-thirds of the physicians surveyed believed that their colleagues had knowledge regarding the medical criteria to diagnose brain-death, but they also indicated that their colleagues are reluctant to approach families. Reasons cited included fear of legal liability, concern about the amount of time involved, and the emotional demands of involvement. The majority of physicians, however, had few reservations about the criteria for declaring brain-death. It is interesting to note that intensive care nurses were more likely than neurosurgeons to consider that organ procurement falls within their definition of professional responsibility (75% of the nursing sample compared to 51% of the physician sample). Among nurses, increased experience with organ donation was related to favorable attitudes toward organ donation. In addition, if the nurses perceived physician support with organ donation, they were more likely to have favorable attitudes toward donation (Prottas & Batten, 1988).

Prottas and Batten conclude that social and interpersonal issues about organ donation presumably predominate over the medical issues. The medical profession has greatly improved its donor management skills, and preserving organs is not an inhibiting factor in the donation process in most instances, as long as the process proceeds within the specific time restrictions for specific donations. To the extent that physician and nurse attitudes may inhibit donation, educational efforts should address physicians, nurses, and all hospital personnel involved in the donation process; and guidance should be available for the sensitive emotional concerns relative to anatomical donation.

The Task Force for Organ Transplantation, sponsored by the U. S. Department of Health and Human Services (1986) recently published the results of a nationwide review and deliberation of literature and research about organ transplantation. According to the report of the Task Force, the religious background of the family and negative attitudes of the next of kin toward organ donation or organ transplantation may influence their decision to refuse donation. In these circumstances, the manner in which these individuals are approached by requestors may be less likely to influence their decision. However, in other circumstances, the decision of the next of kin may be influenced by the manner in which they are asked about organ donation by the requestor.

The persons present at the time of death to support the next of kin, both family and professional staff, are believed by nurses to have an influence on whether consent is obtained (Hart, 1986). Consents are more likely to be obtained if the requestor or the staff on the unit can provide support, answer questions, and acknowledge the feeling of loss and grief.

Other beliefs may inhibit health professionals from making requests for anatomical donations. Some health care professionals believe that a grieving family may not want to be approached about organ donation. However, families have expressed the feeling that donation was a source for comfort (Skelley, 1985). There are many physicians, nurses, and those in the general population who still regard organ procurement as "ghoulish" (Cox, 1986); others believe that the respect of the dead is violated when organs are procured (Hart, 1986; Schaal & Slemenda, 1984). Caplan (1985), who has written extensively on the ethical difficulties of obtaining organs for transplantation notes that health professionals may have concerns that the individuals to be used as organ donors are not dead, despite a declaration of brain death. Patient's diagnosed with brain-death have irreversibly lost the brain's integrative and cognitive functions, but whose cells, tissues and organs remain functioning with the support of respiratory ventilators and other critical care interventions for various periods of time.

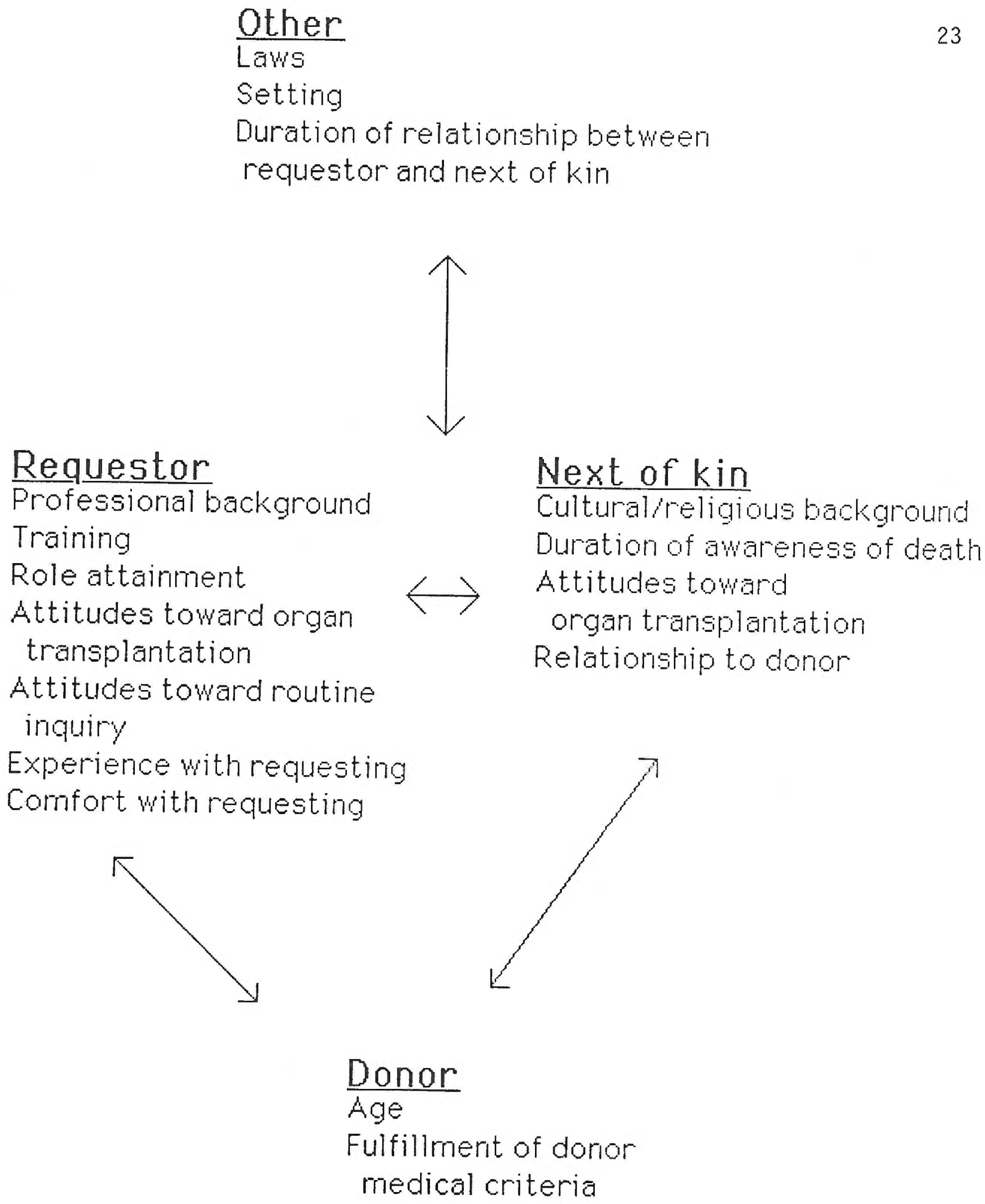
The reasons professionals may choose not to request include difficulty in admitting defeat in the death of the patient, related guilt feelings toward the family in not saving the patient, discomfort in confronting one's own mortality, or not wanting to disturb the family during an emotional crisis (Kaufman, Huchton, McBride, Beardsley, & Kahan, 1979). Some health care professionals doubt that family members are able to give informed voluntary consent in the context of the sudden death of a loved one because relatives may be in a state of shock, disbelief or confusion (Caplan, 1984).

In summary, research has indicated reasons why potential anatomical donors fulfilling medical criteria do not become donors: limited donor management skills, the unavailability of a surgeon to perform the procurement, the inability to obtain consent from the next of kin, or because next of kin are not asked about donation after the death of a family member (Bart, et al., 1981). The attitudes of health professionals toward donation are believed to influence whether next of kin are requested or may influence the decision of the next of kin to donate (Sophie, et al., 1983; Stark, et al., 1984). More research is needed to determine if and how requestor attitudes influence the decision of the next of kin to donate.

The social and interpersonal issues surrounding organ donation, particularly those issues influencing the feelings of physicians toward donation have also been identified as needing additional investigation (Prottas & Batten, 1988). In addition, characteristics of the hospital setting need to be examined to further specify variables affecting routine inquiry. If these variables were identified, hospital settings could be modified to provide an emotionally supportive environment for family members making decisions about donation.

Conceptual Framework

A framework for describing the process of routine inquiry was developed by the researcher on the basis of clinical experiences, a review of the literature, and information obtained through pilot interviews with nine individuals who perform routine inquiry. Figure 1 is a schematic representation of the conceptual framework. The focus of this research was on the request process and does not focus on the success or outcome of the request. Routine inquiry is defined as including the decision of requestors to ask the next of kin about anatomical donation and the requesting process. Anatomical donation is defined as the donation of eyes, bone, skin or internal organs. The following variables are believed to affect routine inquiry in the hospital setting: (1) requestor training, (2) role attainment (whether the role was voluntary or mandatory), (3) requestor attitudes toward organ transplantation, (4) requestor attitudes toward routine inquiry, (5) requesting experience, and (6) comfort with requesting. The variables were believed to be interrelated with each other. For example, comfort with making requests may be related to experience with making requests. Or, knowledge about the grieving process and the positive feelings expressed by family members who have participated in anatomical donation may help requestors feel more comfortable with requesting. For some requestors, the interrelatedness between certain variables may be different than for others. And, it was believed that other variables affecting the



Other
Laws
Setting
Duration of relationship between requestor and next of kin

Requestor
Professional background
Training
Role attainment
Attitudes toward organ transplantation
Attitudes toward routine inquiry
Experience with requesting
Comfort with requesting

Next of kin
Cultural/religious background
Duration of awareness of death
Attitudes toward organ transplantation
Relationship to donor

Donor
Age
Fulfillment of donor medical criteria

Figure 1. Variables Influencing Routine Inquiry: preliminary list and diagram of relationships.

requesting process as it was implemented in three hospital settings might be identified.

Variables relating to the next of kin, including religious background and their personal feelings toward anatomical donation, in addition to variables related to circumstances at the time the request is made (for example, the length of the deceased's illness prior to death) may affect the consent of the next of kin. However, the focus of this study was on describing how the next of kin are asked about organ donation by requestors in a hospital setting, describing relationships among variables related to the requestor, and identifying other variables affecting the requesting process.

Purpose of the Study

Additional research was needed to further specify variables affecting the process of routine inquiry in hospital settings. This information could be used to identify difficulties requestors experience with routine inquiry. In addition, this research helped identify the variables that assist requestors with routine inquiry. If these variables were identified, hospital policies could be modified to facilitate the development of an environment more supportive to obtaining consents for anatomical donation, as the need for organs is expected to continue to increase (Bart, et al., 1981; Koop, 1983).

Research Questions

The research questions, derived from the review of the literature, clinical experiences with routine inquiry, and the conceptual framework include:

(1) Is there a relationship among the following variables:

(a) requestor training,
(b) role attainment (whether the role was voluntary or mandatory),
(c) requestor attitudes toward organ transplantation,
(d) requestor attitudes toward routine inquiry,
(e) requesting experience, and
(f) comfort with requesting?

(2) What other variables influence the practice of routine inquiry in hospital settings?

Chapter II

Methodology

Design

A descriptive design using qualitative methods was used for this research. Data were collected by interviewing nine subjects trained in requesting for anatomical donations. This qualitative method was not based on a grounded theory approach. A qualitative research method using a semi-structured interview was chosen because this method would produce more complete data than a written questionnaire with closed-ended questions. In addition, the researcher was able to ask the individual being interviewed to expand or elaborate on any answers which were unclear.

Qualitative methods have been criticized because of the difficulty of analyzing in an objective and replicable fashion the large amount of narrative material. Furthermore, the small sample usually used for qualitative research may not be representative of the population of requestors (Polit & Hungler, 1987). However, the qualitative method used yielded a rich description of the phenomenon of routine inquiry because data collection was more intensive than if the data had been collected using a quantitative approach.

Subjects were informed that there were no "correct" answers prior to the interview. This was done to help minimize the subjects answering questions as they believed the interviewer preferred them to answer, a threat to external validity. In addition, the requestors were informed that confidentiality would be maintained about their identity and the hospital with which they were affiliated.

A data triangulation strategy was used to collect data in order to minimize issues related to reliability and validity of qualitative research instruments. The triangulation method includes the use of multiple data sources in a study or interviewing multiple key informants about the same topic (Denzin, 1978). Thus, subjects were selected from a convenience sample of three hospitals located in Oregon. One hospital had a transplant program for the transplantation of internal organs. The other two hospitals did not have a transplant program. Three subjects were interviewed from each hospital. The goal was to include at least one subject from each hospital who requested in a critical care or emergency setting, and one subject who had made at least four requests during the last year.

Procedure to Identify Subjects

The research proposal was reviewed by the Oregon Health Sciences University Human Subjects Committee for approval. After approval was obtained by this committee, the proposal was then presented to the Institutional Review Board and/or Nursing Research Committee at the three hospitals from which a sample of subjects was chosen. After approval was obtained to proceed with the research project, an agreement was established with each hospital for the mechanism to distribute the findings after the completion of the study.

Administrative personnel managing the requestor training at the hospitals were notified of the study through a letter (refer to Appendix B for a copy of the letter). A list of the trained requestors and the hospital units worked on was requested in this letter. The researcher met with the personnel managing the requesting training program at one of the hospitals at their request to answer additional questions about the project.

Procedure to Secure Subjects

The goal in securing subjects was to include at least one subject from each hospital who requested in a critical care or emergency setting, since these areas are where most internal organ donors are identified (Bart, et al., 1981), and to include one subject who had made at least four requests during the last year. There were four steps in the process of securing subjects.

Step 1. The list of trained requestors and their work units was obtained from the person managing the requestor training program at each hospital. Numbers were assigned to each requestor, using one of two procedures (Step 2A or 2B).

Step 2A. If the hospital had professionals that requested for all hospital units, all requestors were assigned numbers in a one step process. The selection procedure continued with Step 3.

Step 2B. For the hospitals using requestors with specific unit assignments for critical care or emergency, a two-step process was used. A list of critical care and emergency room requestors was obtained from the person managing the requestor training program in addition to a list of other requestors in the hospital. First, those on the intensive care/emergency room requestor list were assigned numbers and selected randomly (a random number table was used to identify who to call) to be called at the place of employment. The study was explained and participation solicited (refer to Appendix C for a copy of the telephone script). This procedure was continued until one requestor from a critical care or emergency room area agreed to participate. Then, the remaining persons from the critical care and emergency requestor list who had not been contacted were added to the list of other requestors in the hospital, and numbers were reassigned. The procedure continued with Step 3.

Step 3. The requestors were called in random order, the study was explained, and participation was solicited (refer to Appendix C for a copy of the telephone script). They were asked if they had requested at least once in the last calendar year. If the answer was yes, they were asked for the approximate number of requests in which they participated during the last year.

Step 4. If the requestor agreed to participate, a time and place for the interview was selected by the requestor.

One hospital had a policy that protected employees from being contacted at their employment or home phone number. Therefore, the procedure to identify and contact subjects was different for this hospital. After contacting the administrative person managing the requestor training program at this hospital, a list with the names of nurse managers of four hospital units whose staff made frequent requests was obtained. These nurse managers provided a list of 20 requestors (3 to 6 from each unit) who were known to have made at least one request during the last year. A letter explaining the research project and asking for voluntary participation was left in each of the 20 requestors' employment mailboxes (see Appendix D for a copy of the letter). Two of 20 requestors responded to the letters. A third requestor was randomly selected and asked to participate through a telephone call. One subject responded approximately two weeks after the deadline and was not included in the project since nine subjects had already agreed to participate.

There were no refusals to participate. Four requestors were contacted who had not made a request, and could not be asked to participate because they did not meet the criterion of having made one request within the last calendar year.

Procedure for Data Collection

The investigator called the subject 1 to 2 days prior to the day of the interview to confirm the time and place for the interview. Prior to the beginning of the interview, each requestor signed an informed consent form (refer to Appendix E for a copy of the consent form).

Information identifying the requestor or the institution was excluded from the interview data to protect confidentiality. Data from each interview was given an identification number. A log indicating the identification number and the identity of the requestor was kept separate from the interview data. This log also contained the phone number of the requestor should the researcher need to clarify any of the interview data at a later date. The log was destroyed once the project was completed.

The data were collected through individual semi-structured interviews with requestors. All interviews were conducted by the researcher. Interviews lasted between forty minutes to one hour and fifteen minutes. Most interviews lasted one hour. Requestors openly verbalized positive and negative feelings about routine inquiry. Two requestors stated that the interview encouraged them to examine their practice of routine inquiry.

Eight interviews were audio taped with the permission of the requestors. One requestor refused to be tape recorded. The audio tapes were used to cross validate written data typed on a word processor. A printed copy of the data was generated from a computer floppy disk, and the data were stored on a hard disk to protect against the loss of data. Tapes and computer disks were erased upon completion of the project.

Instrument

The instrument used for data collection was a semi-structured interview guide developed by the researcher (refer to Appendix F). It consisted primarily of open-ended questions developed to gain more information about how routine inquiry is performed in hospital settings. These interview questions elicited information about the variables related to the requestor: (1) requestor training, (2) role attainment (whether the role was voluntary or mandatory), (3) requestor attitudes toward organ transplantation, (4) requestor attitudes toward routine inquiry, (5) requesting experience, and (6) comfort with requesting. The first three questions obtained information about how the person became a requestor and the type of training he/she received. This information was obtained because varying levels of experience and preparation could affect how the requestor answered the remaining questions. Information about hospital procedures was obtained (questions 4, 5, 6, 7, 8, and 9). Requestors were asked to describe some of their own experiences with routine inquiry and how they make requests (questions 10, 11, 12, and 13). Finally, the requestor was asked to describe aspects of routine inquiry that worked well and also any difficulties that existed with the current procedure as it was practiced in his/her institution (questions 13, 14, and 15).

An initial version of the instrument was piloted with three requestors. As a result of the pilot study, questions were reordered and reworded so that they promoted more spontaneous discussion of routine inquiry and encouraged requestors to describe their personal experiences. Questions asking information about which individuals perform routine inquiry and the role of the physician in the process were also added to the instrument. Although a question directly asking about requestors' attitudes toward organ transplantation is not included in the guide, the requestors' perception was clearly verbalized in each pilot interview so a question was not added to the guide relating to the topic. A question asking about which cultural or religious groups should not be requested was also added to the instrument since the first few requestors interviewed contributed conflicting information about this topic.

The interview guide was used to conduct a semi-structured interview with each requestor participating in the research project. In so far as possible, an effort was made to ensure that all topics were addressed. If subjects did not spontaneously describe their experience in ways that made apparent whether specific variables were linked, a probe question was asked to elicit subjects' perceptions of relatedness among variables. For example, "Does more experience with requesting make you more comfortable with the process?" And, requestors were asked during the interview to elaborate on content which was unclear to the researcher.

Data Analysis

Data analysis began after the first interview data were collected and continued until all of the interviews were completed. Analysis began with a search for themes, recurring concepts, or significant pieces of data. Data were identified as significant if they described a problem, a positive or negative event, or a recurring concept or theme relating to routine inquiry.

The pieces of data identified as significant by the researcher were highlighted or underlined on the typewritten copy of the data, and then coded. Coding refers to the process where a researcher develops a one or two word description or code to describe recurring concepts or themes, or data identified as significant by the researcher (Polit & Hungler, 1987). The codes associated with specific subjects were tabulated in order to identify which concepts occurred more frequently for particular subjects or groups of subjects. Lastly, these coding categories were used to develop the description of the variables affecting routine inquiry and to expand the original framework. The frequency with which certain themes or recurring concepts were tabulated.

Each category contained a description of the characteristics that seemed to be related to it. And the identification number of the interview from which the code was identified was also documented so that the researcher could review raw interview data to identify similarities and differences between the data relating to each code. The coding process continued until all interview data were collected.

Nurses with expertise in qualitative data analysis and a nurse requestor who participated in the development of a educational program to train hospital staff as requestors assisted the researcher in summarizing the results of the study. A summary of the results is presented in Chapter III.

Chapter III

Results and Discussion

In this chapter, the results of the interview data are discussed. The purpose of this project was two-fold:

(1) To determine interrelationships among the following variables:

- (a) requestor training,
- (b) role attainment (whether the role was mandatory or voluntary),
- (c) requestor attitudes toward organ transplantation,
- (d) requestor attitudes toward routine inquiry,
- (e) requesting experience,
- (f) comfort with requesting, and

(2) To identify other variables that influence the practice of routine inquiry in hospital settings.

First, demographic information on the requestors is presented. Then, results of the interview data are discussed according to the two research questions. For research question (1), data on each variable is described, followed by a description of the interrelationships among the variables. Selected quotations from subjects are used to illustrate some variables and relationships between variables. Then, research question (2) is discussed. The chapter concludes with additional findings and a revised conceptualization of the variables affecting routine inquiry.

Requestor Demographics

All of the subjects were registered nurses. Five had nursing management or supervisory roles. Two were intensive care nurses, one was a nurse who provides information and support for patients' families while patients are in the operating room, and one was a hospice nurse. Each subject interviewed had been a requestor since the routine inquiry law was passed in Oregon in 1985. Five of the requestors had made less that 4 requests during the last year, and 4 of the requestors had made 4 or more requests during the last year.

Research Question (1): Interrelationships Among Variables

Requestor Training.

In hospital # 1, thirteen requestors were trained through a one-day classroom and seminar session that consisted of lectures addressing topics such as the routine inquiry law, specific beliefs about anatomical donations among different cultural and religious groups, donor criteria for specific types of donations, and the grieving process. The training also included a session of role playing through which the requestors were able to exchange and practice the roles of being both the requestor and a family member being asked about anatomical donation. All three subjects stated that adequate information was provided and that they felt satisfied with the content provided in the training program.

In hospital # 2, forty-three requestors were trained through a program lasting one-half day. It included content about the routine inquiry law and information about donor criteria for specific donations. The training session also included a period of role playing where participants exchanged and practiced the roles of being a requestor and a family member to learn how to make the family more comfortable at the time of the requests. Finally, the requestors toured a tissue bank.

From the sample of requestors from this hospital, only one completed the requestor training program offered by the hospital. This requestor perceived the content relating to the routine inquiry law, the need for specific donations, and the donor criteria needed for specific donations as helpful. However, the role playing session was not perceived as helpful because this requestor's nursing experience provided experience working with families experiencing a crisis situation.

The second requestor from this hospital already had previous involvement with the Oregon Donor Program before the routine inquiry law came into effect and did not attend the hospital training program because she did not feel that additional training was necessary to fulfill the requestor role. The third requestor from this hospital received training from a workshop presented by the Oregon Donor Program but couldn't remember specific content. All requestors felt prepared to fulfill the requestor role after completion of their training.

Hospital # 3 presently has about one hundred trained requestors. However, the training program has changed from the time the first training program was initiated after the routine inquiry law was passed in 1985. The three subjects interviewed from this hospital were trained through the initial training program. It included a presentation of information about the routine inquiry law, a session of role playing through which requestors exchanged and practiced the roles of being a requestor and a family member, and a question and answer session where requestors were allowed to ask questions and verbalize personal feelings about the law and requesting families for donations.

Approximately one year after the initial training session, the same requestors were shown a videotape as a "refresher". The videotape method is the present method of training requestors. The videotape characterized different situations where family members are asked about donation and suggested different ways to approach family members about the topic. The videotape was described by one requestor as "very emotional", but as good as the classroom training method. The other two requestors, who also participated in both training sessions, believed that the classroom method of training was more beneficial because it included a question and answer session which allowed requestors to verbalize their personal feelings about routine inquiry. A question and answer session was not included with the videotape training method.

In summary, the three training programs at the hospitals from which the sample of requestors was selected included content about the routine inquiry law and information about how to approach a family about donation and reviewed the medical criteria that must be fulfilled before the deceased can be considered as a potential donor. All subjects verbalized that their training programs had provided enough information to help them perform the requestor role. In the training sessions, a question and answer session allowed requestors to verbalize their feelings about routine inquiry and how they felt about approaching persons about the subject of organ donation. Six requestors indicated that a question and answer session had been very helpful in assisting requestors to feel more comfortable with the new role.

Requestor Role Attainment. Requestor role attainment refers to how the subject acquired the role of requestor. Eight of the 9 requestors attained the role of a trained requestor because of their nursing management positions or because of the specific unit in which they worked (e.g., intensive care, operating room). Five of the subjects were selected by administrative personnel at their hospitals to participate in the hospital's requestor training program because of their nursing supervisory positions. The other four subjects were strongly encouraged by their nurse managers to become trained requestors, but participation in the training program was not mandatory.

Although the staff nurses were "strongly encouraged" to become trained requestors, they did not feel pressured by hospital management. Three of the staff nurse requestors interviewed stated that if they or any other staff nurse on their unit felt uncomfortable making a request, another staff nurse or nursing management person was available to assist them with the request or with the completion of routine inquiry paperwork.

The variable of role attainment did not seem to be interrelated with other variables. Several subjects (n=8) were selected by hospital management personnel to become trained requestors. Though some subjects (n=4) verbalized ambivalent feelings about routine inquiry, they indicated that they were committed as nurses to help the family make a decision in an emotionally supportive environment.

Attitudes Toward Organ Transplantation and Routine Inquiry. Seven requestors interviewed expressed positive feelings toward the concept of organ transplantation. However, feelings were verbalized by two subjects about the uncertainty of the value of transplantation, and the rationale for the increased financial funds needed for transplantation was questioned. The reflections of one requestor illustrate this questioning:

> People are put through these agonizing situations just to prolong their lives, for what? For how long and for what quality?...I know the survival rates are increasing all the time and many people are benefiting, but they haven't given us much long term survival information. We don't know if they are surviving very long.

Five requestors expressed positive feelings toward organ transplantation and routine inquiry. However, 4 of the 5 requestors who felt positively about routine inquiry also verbalized some degree of discomfort with making requests. Two of the subjects verbalized discomfort with requesting, yet verbalized support for the transplantation program: "I still feel uncomfortable because I am not sure how I would react if I were the person being asked. Yet, I believe strongly in the (transplantation) program and making it work."

Two requestors verbalized negative feelings toward organ transplantation and routine inquiry. Reasons identified for these feelings included the issue of transplant funding as an ethical conflict. Ambivalent feelings about physiological maintenance of the donor (the use of a respiratory ventilator for artificial ventilation, massive amounts of intravenous fluids, medications to maintain blood pressure) were verbalized. However, requestors with negative or uncertain feelings about the routine inquiry law felt committed to adhering to the routine inquiry law and their hospital policy regarding routine inquiry, and attempted to make requests in an emotionally supportive environment for the family.

Subjects' attitudes toward routine inquiry seemed to be related to their attitudes toward organ transplantation. Five subjects verbalized positive feelings toward the concepts of organ transplantation and routine inquiry, 2 subjects verbalized negative feelings toward the concepts of organ transplantation and routine inquiry, and 2 subjects verbalized support of the transplantation concept, but were unsure of their feelings about routine inquiry, or if routine inquiry should be the manner through which organs are obtained for donation and transplantation.

Comfort with Requesting. Only 2 requestors denied being uncomfortable with making requests, and 7 of the 9 requestors interviewed described some degree of discomfort. Selected quotations from interview data are provided to illustrate this concept. Reasons for the discomfort included the requestor's uncertainty of personal feelings about anatomical donation. "I never really feel comfortable with it. I sometimes think about how I would react. I haven't been in that situation yet where I've had to give consent...I guess there's the thought - can I really be asking of someone else something that I could not do myself?"

Another source of discomfort was related to requesting family members who are grieving over the loss of a loved one. Requestors feared inducing more stress upon grieving family members: "I don't feel opposed to the idea of donors, but it's hard to approach a family and say to them that you have one more decision to make."

Discomfort was also verbalized when requestors asked family members whose cultural beliefs were unfamiliar to the requestor. Various responses were received from the interview question "are there any cultural groups or religious groups that you might not request?" Answers included American Indians (n=1), Asians (n=1), Latin Americans (n=1), Chinese (n=1), and Gypsies (n=2). Most subjects (n=8) believed that all groups should be asked regardless of their cultural or religious background.

Some requestors choose not to request next of kin because they felt uncomfortable making the request, even if the deceased fulfilled the medical criteria for donating in some circumstances:

> There have been (other) times when I felt uncomfortable about asking and not asked just to spare the family...like if the patient is around fiftyish and may be borderline for the donation of a heart or kidneys...I know others that have done this also. And I do think that they cheat on the forms a little bit and say "yes, they were requested but turned it down". Those cases are rare but I think they happen.

Requestors described a variety of ways in which they attempt to lessen their own discomfort with requesting. Requesting experience and practice were believed to make the process easier because the requestor learned varied approaches to use with different personalities. Some requestors reinforced themselves with the belief that organ donation would be a comfort later (for the family), though the request may be uncomfortable for the requestor and the family at the time of the request.

Conferring with a physician was helpful if the requestor was unsure if a request for donation was appropriate for a family, and helped the requestor to better understand the specifics of the patient's illness before the request was made. Making the request gentle, but as quick and easy as possible lessened the discomfort for some requestors. Or, an explanation of the Oregon routine inquiry law to the family members provided a rationale for asking about donation when requestors were uncomfortable asking. Finally, familiarity and rapport with the family or patient (as in the event of terminal illness) contributed to requestors feeling more comfortable with requesting.

Some requestors indicated that one-half hour was sufficient for meeting the family, answering questions, and making the request. Requestors indicated that any additional time with the family prior to making the request allowed them to establish better rapport with the family.

Summary of Interrelationships Among Variables. Requestor attitudes toward the concept of organ transplantation seemed to be related to their attitudes toward routine inquiry. Positive attitudes toward both organ transplantation and toward routine inquiry were identified in subjects (n=5); negative attitudes toward organ transplantation and routine inquiry were also identified (n=2). Two subjects indicated that increased requesting experience lessened discomfort with requesting. Comfort with requesting was related to the training program, as subjects (n=6) indicated that a "question and answer session" of their training program (that part of their training program allowing verbalization of feelings about the routine inquiry law and about approaching family members about anatomical donation) helped them feel more comfortable with routine inquiry. No relationship among the variable of role attainment and the other five variables was identified.

Research Question (2): Other Variables Influencing Routine Inquiry

Proper completion of request forms, establishing rapport with the next of kin, a support group for requestors, physician knowledge of and attitudes toward anatomical donation, and public education were additional variables affecting routine inquiry identified by subjects. The proper completion of request and consent forms was important for the donation and procurement to proceed in a timely manner. Three requestors from one hospital fulfilled the requestor role for all units of their hospital. Because physicians were responsible for the completion of routine inquiry paperwork, requestors were not notified of all hospital patient deaths. And, a few instances were noted in which requests forms were neglected, completed incorrectly, or the family had to be requested by telephone after they had gone home.

Subjects (n=9) verbalized the importance of establishing rapport with the next of kin prior to making a request for donation. Requestors from all three hospitals indicated that the family is usually taken to a quiet room, where they are offered coffee and allowed to ask questions about the donation and procurement process. Subjects from each of the three hospitals believed their hospital procedure of implementing routine inquiry allowed them to establish enough rapport with the family prior to the request.

Subjects from one hospital described the development of a requestor support group as a mechanism for developing solutions to problems related to routine inquiry in their hospital setting. In addition, the group allows requestors to share experiences, and provides a channel for requestors to vent their feelings about routine inquiry. An example of problem solving was explained, with the routine inquiry form being changed to make it easier to complete.

Another variable affecting routine inquiry identified from the interview data was physician knowledge of and attitudes toward anatomical donation. Some requestors believed that more education was needed to improve physicians' communication skills with requesting, so that families are requested in an unpressured manner. In addition, some next of kin were not requested for donation because the physician had negative attitudes toward routine inquiry or the concept of anatomical donation. The physicians believed they were reducing the emotional burden of the family. By not requesting, however, physicians denied families the opportunity to decide. Requestors suggested an education program for physicians to include more information about the law related to routine inquiry and how to approach next of kin about the subject.

A stronger focus on public education to encourage families to think and talk about anatomical donation was also suggested. Encouraging the public to discuss their wishes about donation with their families would make the decision easier for family members who might have to make this decision.

Finally, the type of hospital unit where the request was made affected routine inquiry. Differences were noted in the implementation of routine inquiry in intensive care units as compared with acute hospital units. The physician was more frequently involved in requests made in intensive care units, due to physician's diagnosis of brain-death. Subjects with experience requesting in intensive care units noted that requesting for internal organ donations in these units is often dependent on the physician's diagnosis of brain death.

The patients that are diagnosed with brain death are often potential donors for internal organ donations as hearts, kidneys or livers. Requestors who practiced routine inquiry in acute hospital units indicated that requesting was not as complex as those requests made in critical care units because the deceased was usually only eligible to donate eyes, skin, and bone, and the medical criteria are not so specific for these donations as for internal organ donations. Physiological maintenance of the donor is not necessary as it is for internal organ donations. Therefore, the physician is not consulted as frequently by the requestors on acute care units unless indicated by the hospital policy.

Additional Findings

Some subjects referred to their nursing background during the interviews and attributed some of their skills in making requests to their background as nurses. Although some requestors did not believe that routine inquiry was the most appropriate way to increase the number of organs for donation, they stressed the importance of performing the request in an emotionally supportive environment.

No differences were noted in routine inquiry as it was implemented in the hospital with an organ transplant program when compared with two hospitals not having transplant programs. The Organ Identification Manual was identified as a helpful resource by most requestors, and no requestors verbalized difficulty in locating the manual.

Revised Conceptualization

A revised conceptual framework of the variables affecting routine inquiry in hospital settings is presented in Figure 2. This revision was based on the findings for the research questions. One variable related to the requestor (role attainment) was dropped from the preliminary framework. Five variables were added. (Refer to figure 1, page 23 and Figure 2, page 55.) All other variables were kept in the final

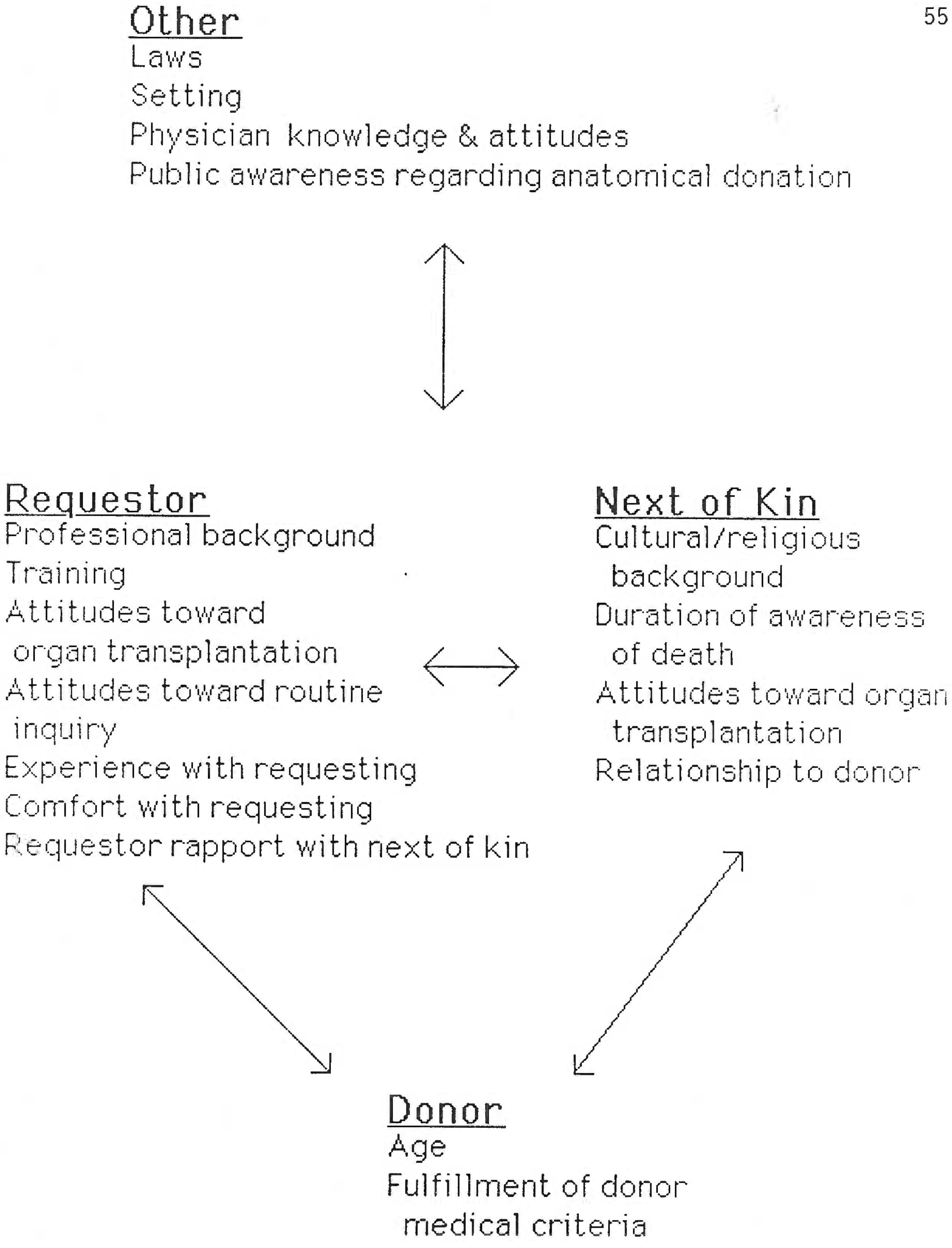


Figure 2. Conceptual Framework of Variables Influencing Routine Inquiry.

conceptualization of the variables influencing routine inquiry.

The variable of role attainment (whether the requestor role was voluntary or mandatory) was not identified as being related to the other variables after the data were analyzed and was excluded from the revised framework. Variables added to the framework included physician knowledge and attitudes about anatomical donation, and public awareness regarding anatomical donation. The variable duration of the relationship with next of kin was changed to requestor rapport with the next of kin, and was moved under the category of requestor. In the preliminary framework, this variable was placed under the category of other, until data were collected. Variables added to the framework related to the hospital setting were requestor awareness of patient deaths, completion of request and consent forms, a mechanism to identify and solve problems related to routine inquiry as it is implemented in hospital settings, and the unit where the donor is receiving care. All other variables in the framework developed prior to the study were still believed to affect the process of routine inquiry, although the study did not elicit specific information addressing all of the variables.

Chapter IV

Summary and Recommendations

Hospitals in Oregon have implemented policies and procedures to comply with the requirements of the routine inquiry law, which requires hospital personnel to ask the next of kin about anatomical donation when a family member has died. In Oregon, the routine inquiry law was passed in 1985. This qualitative study obtained data about the process of routine inquiry as it was practiced in hospital settings.

Relationships among the following variables were examined: (1) requestor training, (2) role attainment (whether role was mandatory or voluntary), (3) requestor attitudes toward organ transplantation, (4) requestor attitudes toward routine inquiry, (5) requesting experience, and (6) comfort with requesting, and identified other variables influencing routine inquiry as it was implemented in three hospitals in a Northwest state.

This chapter presents a summary of the results of this study. Research methods are evaluated with limitations of the study identified. The implications for nursing practice and potential utilization of the findings are then discussed. Finally, recommendations for future research are suggested.

Summary of Results

Requestor attitudes toward the concept of organ donation seemed to be related to requestor attitudes toward routine inquiry. Positive attitudes toward organ transplantation and routine inquiry were identified in subjects (n=5); negative attitudes toward organ transplantation and routine inquiry were also identified (n=2). Two requestors indicated that increased experience with requesting lessened their feelings of discomfort with requesting. However, comfort with requesting was also related to the training program. The "question and answer session" of the requestor training programs (the part of the program allowing verbalization of feelings toward the routine inquiry law and about approaching family members about anatomical donation) helped subjects feel more comfortable with routine inquiry. No relationship among the variable of role attainment and the other five variables was identified.

Other variables affecting the practice of routine inquiry identified from the interview data were the following:

1. Failure to notify the requestor of hospital patient deaths was identified as a problem in one

hospital where requestors made requests for all units of the hospital;

2. Proper completion of request and consent forms so the donations can be procured within the specified time restrictions;

3. Requestor establishing rapport with the next of kin;

4. Physician knowledge and attitudes that support or do not support the routine inquiry process;

5. Extent to which families talked with each other about their wishes regarding anatomical donation;

6. Whether the donor was cared for in an intensive care unit.

Summary of Research Methods

The researcher used purposive sampling to select 9 subjects (3 requestors from each of 3 hospitals located in Oregon) for participation in an interview to learn more about the process of routine inquiry. Most research about routine inquiry has been limited to intensive care personnel. This study elicited information surrounding routine inquiry as it was implemented in intensive care units and acute care units of the hospital. However, a study with random sampling of a larger number of requestors from all hospital units and more hospitals would increase the generalizability of the results.

Soliciting subjects by telephone for voluntary participation in the project was more time consuming that soliciting subjects through letters placed in their employment mailboxes because of the difficulty in contacting subjects who worked evening and night shifts. However, of the twenty letters left in employment mailboxes at one hospital, two subjects responded and participated. There were no refusals of subjects contacted by telephone.

The open-ended questions and interview method allowed the collection of more complete data than could have been obtained from a written questionnaire with closed-ended questions, and was useful in identifying new variables affecting to the process of routine inquiry. However, these methods of collecting data limited the number of subjects that could be included in the study. In addition, the research method and sample size made it impossible to ascertain the significance of the interrelationships among the variables.

Implications for Nursing Practice

Nurses frequently fulfill the requestor role in hospitals, and are resources for physicians with questions of about routine inquiry procedures, or may work together with physicians when making requests. Seven subjects expressed some degree of discomfort with routine inquiry. There are a number of approaches that might alter this situation.

First, data from this project support the importance of including a question and answer session in requestor training programs. Second, the availability of a support group can assist requestors with expressing ambivalent feelings about routine inquiry and can be helpful in solving problems with routine inquiry as it is implemented in their hospital setting. Third, the results of this study should encourage personnel managing routine inquiry programs to examine their current policies and procedures related to routine inquiry, especially regarding: 1) the number of people they have trained, to determine whether it would be preferable to have fewer requestors making requests but more experienced individuals or those exposed to more extensive training; 2) the need to gain permission of physician before requests are made; and, 3) evaluation of routine inquiry as it is implemented in the hospital. A survey with hospital requestors would help determine which aspects of the program are working well and what might be most helpful to make the process more easily accomplished.

Requestors must be educated about the positive feelings families experience after making a donation. Negative feelings of family members having experienced a donation were identified with the manner in which they were requested rather than the request itself. For example, clarification of the deceased's prognosis prior to making a request, allowing time for the family to assimilate the diagnosis, and the manner in which families are requested can impact families' feeling about a donation experience (Morton & Leonard, 1979). Requestors have some control in the manner in which the request is made in most instances, and can help prevent these occurrences.

Some family members of patients who were diagnosed with brain-death were concerned that they had been asked about organ donation before the patient's death had been declared; others suffered stress when offered the opportunity to donate because they had to be later informed that the organs they consented to were unacceptable for donation (Tolle, Bascom, Hickam, & Benson, 1986; Tolle, Bennett, Hickam, & Benson, 1987). Or, more organs were removed than had been consented to (Bartucci, 1987). However, the physicians and nurses working with family members could help prevent these occurrences.

Suggestions have been made to assist nurses and physicians making requests of families. The need for sensitivity and attention to detail when informing the family of the death, and during the time when the request is made is essential. Timing may be critical to sensitive requesting. Only after the physician conveys the hopelessness of the prognosis and the family has had time to assimilate the information given to them should the request be initiated (Tolle, et al., 1986). Then, after the request is made, clarification of the consent for anatomical donation would prevent the procurement of organs or tissues to which the family has not consented.

The concern about the inappropriateness of request to some cultural and religious groups has basis in what is known about beliefs and values of those groups. The American Indians, the Chinese, and some Southeast Asians believe strongly that the body is sacred, on loan to the mortal being, and for this reason must be left intact so that it can be returned and available for reincarnation. If organs are removed, the mortal soul cannot ascend into the afterlife (Tolle, et al., 1987). Some Orthodox Jewish scholars do not accept brain death as a criterion for death (Jakobovits, 1983); Johovah's Witnesses do not support anatomical donation or transplantation, and Christian Scientists rarely consent to donation (May, 1985). Yet, the families of each deceased patient should be given individual humanistic consideration, and that even in the cases of strong faith or belief, family preferences should be respected but not assumed to be negative (Tolle & Girard, 1983; Tolle, et al., 1987). Educating requestors about various cultural or religious beliefs surrounding anatomical donation could decrease the discomfort or uncertainty that requestors experience when approaching families having cultural or religious beliefs unfamiliar to the requestor.

Recommendations for Future Research

Research has not been done to determine if of whether requestor attitudes affect how requests are made, or, whether their attitudes affect the response of the next of kin to consent to donation. The use of a quantitative instrument for the study of requesting process and outcome would identify more specifically the frequency with which certain variables affect the process of routine inquiry. The use of a questionnaire with a Likert scale would allow the positive or negative attitudes of requestors toward requesting and/or anatomical donation to be measured. An instrument using a Likert scale could also be used in future research to identify how frequently specific variable affect the system of routine inquiry. Continued research of the donation experiences of families will provide valuable information for health professionals about the specific interventions provided by health care personnel that contributed to making the donation experience positive or negative. Finally, additional research is needed to determine if hospitals in Oregon are complying with the routine inquiry law.

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Appendix A

Oregon Administrative Rules
Chapter 333, Division 72 - Health Division
Organ and Tissue Donation

Request for Tissues and Organs

333-72-100 (1) When death occurs in a hospital, the hospital administrator or designated representative shall request the next-of-kin (as defined in this rule to consent to the gift of all or any part of the deceased's body as a an anatomical gift). The request will not be required if:

(a) The hospital has received communication expressing the wishes of the deceased or next-of-kin in this matter; or

(b) Medical criteria indicate that the deceased would not yield usable organs or tissue, and that the body of the deceased would not be useful; or

(c) When next-of-kin are not available by reason of:

(A) Inability to locate in a timely manner; or

(B) Medical or emotional circumstance in which the request would contribute toward severe emotional distress;

(C) Mental Incompetence; or

(D) The medical examiner objects to any anatomical gift.

(2) Next-of-kin means one of the following persons highest in order of priority listed, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the deceased or actual notice of opposition by a member of the same or a prior class:

(a) The spouse;

(b) A son or daughter 18 years of age or older;

(c) Either parent;

(d) A brother or sister 17 years of age or older;

(e) A guardian of the deceased at the time of death;

(f) Any person authorized or under obligation to disposes of the body.

(3) The hospital shall document the request, or the absence of a request, in the medical record of the deceased on a form set out in Exhibit 1 of these rules, and provide information on the request and its disposition to the person filing the death certificate.

(4) An anatomical gift by a next-of-kin or authorized person may be made by a document signed by

the donor or made by his or her telegraphic, recorded telephonic or other recorded message. The document or recorded message shall contain substantially the information set out in Exhibit 2 of these rules.

(5) A hospital or trained requestor who acts or omits to act with probable cause in accord with the terms Of ORS 97.250 to 97.290 and these rules is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the act or omission.

<u>Training for Requestors</u>

333-72-105 (1) All persons making requests for donations of organs and/or tissues shall have received training in accordance with this rule.

(2) Training for requestors shall include but not be limited to:

(a) The legal requirements or ORS 97.250-97.300 and these rules, and the necessity for completion of the portion of the death certificate regarding organ donation requests.

(b) Specifics of organ donation, including: identification of potential donors: of transplant programs, reimbursement mechanisms for expenses relating to organ retrieval;

(c) A review of the psychological, social, ethical and religious factors affecting willingness to donate organs and resistance to organ donation, and a review of materials developed to train individuals to request organ donation in an appropriate and sensitive manner;

(d) The family's right to refuse, and the need to respect this right;

(e) Circumstances which result in the unsuitability of anatomical gifts;

(f) The effect on funeral arrangements and cost;

(g) The importance of consulting with the attending physician.

(3) Requestors shall be able to demonstrate knowledge of the training as defined in this rule.

<u>Hospital Compliance</u>

333-72-110 (1) Hospitals shall demonstrate compliance by maintaining a file, available for Health Division review, including the following:

(a) Training curriculum;

(b) Hospital policy and procedure regarding request and training for tissues and organs;

(c) If not included in policy and procedure, criteria for selection of a requestor; and

(d) Policies and procedures for communicating with donor programs regarding the availability of donor organs.

(2) Each hospital shall provide a copy of the information required by section (1) of this rule to the Health Division no later than February 1, 1986.

Appendix B

Letter to Administrative Personnel Managing Requestor Training Programs

THE OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, L343, Portland, Oregon 97201 (503) 279-7709

School of Nursing
Community Health Care Systems

March 31, 1988

To: Managing Personnel of training program to train staff in the process of requesting for anatomical donation.

From: Karen Suchowski, R.N., B.S.
Graduate Nursing Student
Oregon Health Sciences University

Subject: Participation in research project.

I am a graduate nursing in the School of Nursing at the Oregon Health Sciences University and I am doing a research project to learn more about the process of routine inquiry, or the process of asking the next of kin about anatomical donation when a family member has died. The project has been approved by the Human Subjects Committee at the Oregon Health Sciences University and the Institutional Review Board at your hospital. I am interested in interviewing three requestors from your hospital. The interviews will take approximately one hour and the identity of the requestor and the institution of affiliation will remain completely confidential.

This letter is to inform you of the project and to request a list of a list of the requestors at your hospital along with the hospital unit and phone number of the requestor. I will be contacting the requestors by telephone and asking for voluntary participation in this project. A self-addressed envelope is enclosed for your convenience in sending me this information. If you have any questions about this project, I can be reached at 274-4296.

Thank you,

Karen Suchowski, RN

Karen Suchowski, R.N.,B.S.N.

Schools:
Schools of Dentistry, Medicine, Nursing

Clinical Facilities:
University Hospital
Doernbecher Memorial Hospital for Children
Crippled Children's Division
Outpatient Clinics

Special Research Division
Vollum Institute for
Advanced Biomedical Research

Appendix C

Script for Telephone Call to Contact Requestors

My name is Karen Suchowski. I am a graduate student in the School of Nursing at the Oregon Health Sciences University and I am interested in learning more about the process of routine inquiry, or the process of asking next of kin about anatomical donation when a family member has died. I received your name from (state name of personnel managing the requestor training program at specific hospital). Have you done a request for donation within the last year? (If yes, information will be collected about how many requests were done within the last year and whether the person requested in a critical care or emergency area.)

I am calling to ask for your voluntary participation in a research project. The project has been approved by the Human Subjects Committee and/or Institutional Review Board at your hospital. I am interested in interviewing you to learn about some of your experiences in making requests, how you view routine inquiry, and your opinions about the process as it currently implemented. The interview will last approximately one hour and can be done at a time and place which is most convenient for you. Your identity and the institution you work at will remain completely confidential.

Do you have any questions? Would you be willing to participate? (If the person is willing to participate, a time and place will be arranged.)

Appendix D

Letter to Requestors Soliciting Participation for the Project

April 25, 1988

To: Individuals Trained to Request for Anatomical Donation at ______________ Hospital.

From: Karen Suchowski, R.N., B.S.
Graduate Nursing Student
Oregon Health Sciences University

Subject: Participation in Student Research Project.

I am a graduate nursing in the School of Nursing at the Oregon Health Sciences University and I am doing a research project to learn more about routine inquiry, or the process of asking next of kin about anatomical donation when a family member has died. The project has been approved by the Institutional Review Board and Nursing Research Committee at _____________ Hospital. I am requesting your voluntary participation for an interview so that I can learn about some of your experiences in making requests and your opinions about the process as it is currently implemented.

The interview will last approximately one hour and can be done at a time and place which is most convenient for you. I am using three hospitals in the project. Your identity and the hospital with which you are affiliated will remain completely confidential.

If you are willing to participate, or have any questions about the project, please call me at 274-4296. You're input would be greatly appreciated. I am doing this project to obtain information about variables that affect the requesting process as it is practiced in hospital settings, and to learn how requesting can be made less difficult for the requestors and family members.

Thank you,

Karen Suchowski, R.N.,B.S.N.

Appendix E

Consent Form

Oregon Health Sciences University
School of Nursing
Consent Form

Investigation: Requesting for Organ Donation in Hospital Settings
Investigators: Karen Suchowski, R.N., B.S.
Caroline White, R.N., Dr.P.H.
(Master's Research Project Advisor)

Karen Suchowski, a graduate student in the School of Nursing, is doing a research project designed to understand more about the process of routine inquiry. Routine inquiry is the process of asking next of kin about anatomical donation when a family member has died. She would like to learn about some of your experiences in making requests, how you view routine inquiry, and your opinions about the process as it currently implemented.

I understand that if I agree to participate in this project, Ms. Suchowski will be asking me questions through an interview that will last approximately one hour. I also may give my approval to have the interview tape recorded to help the interviewer record the information. This decision will be made at the time of the interview. I also may give my permission at the time of the interview to be contacted after the interview is completed to clarify any information that is unclear.

I understand that I may benefit from participating in this project because the interview may assist me in evaluating my practice of routine inquiry. I also understand that it may be difficult to discuss certain content but that this information may help health care professionals to better understand the process of routine inquiry.

My identity as the requestor being interviewed and the institution of which I am affiliated will remain confidential. I understand that neither my name nor the hospital with which I am affiliated will be used for publication purposes and that I am free to refuse to participate or to withdraw from this project at any time without affecting my relationship with or treatment at the Oregon Health Sciences University.

The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability

Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the university, its officers or employees. If you have further questions, please call Dr. Michael Baird at (503) 279-8014.

Dr. White (279-7709) or Karen Suchowski (274-4296) will answer any questions that I might have about the project. I have read the foregoing and agree to participate in this project.

____

Requestor's signature/date

____

Witness

____

I approve tape recording (initial)

____

I approve future contact to clarify information (initial)

Appendix F

Interview Guide: Key Questions

1. How did you become a requestor?
2. How long have you been a requestor? Approximately how many requests have you performed?
3. Describe the training that you received to become a requestor.
4. How are you notified of a death in the hospital?
5. Who usually makes the request? (apply question to own unit if applicable)
6. What is the role of the deceased's physician(s) or other responsible physician(s) in the process?
7. Are physicians trained requestors?
8. How has this affected your role?
9. How familiar is the next of kin with the individual performing the request?
10. What are some things that tell you that the family is ready to be asked about donating organs?
11. Are there any cultural or religious groups that you would not request?
12. Describe how you begin the requesting process for organ donation.

13. Have you ever felt uncomfortable making a request? (describe) How did you deal with these feelings?
14. Have you encountered any problems while performing routine inquiry in the hospital setting? What solutions would you recommend to solve them?
15. Are there things with routine inquiry that are working well in your hospital? What are they?
16. Do you have any other comments that you'd like to share regarding routine inquiry?

AN ABSTRACT OF THE
MASTERS RESEARCH PROJECT OF
KAREN A. SUCHOWSKI

For the MASTER OF SCIENCE

Title: REQUESTING FOR ANATOMICAL DONATION IN HOSPITAL SETTINGS: A DESCRIPTIVE STUDY

Approved: ________________________________

Caroline M. White, R.N, Dr.P.H., Professor,
Masters Research Project Advisor

The purpose of this descriptive study was to gain more information about routine inquiry, the process by which next of kin are asked about anatomical donation in a hospital setting. This study examined relationships among the following variables: (1) requestor training, (2) role attainment, (3) requestor attitudes toward organ transplantation, (4) requestor attitudes toward routine inquiry, (5) requesting experience, and (6) comfort with requesting. And, a framework describing the factors influencing the requesting process was elaborated and clarified.

Data were collected through personal interviews with nine subjects trained and experienced in requesting next of kin for anatomical donation from

three hospitals in a Northwest state. Open-ended questions provided structure for the interviews.

Positive attitudes toward both organ transplantation and routine inquiry were identified in subjects (n=5). Negative attitudes toward organ transplantation and routine inquiry were identified (n=2). Increased requesting experience lessened the discomfort with requesting (n=2). A question/answer session in the requestor training program helped subjects feel more comfortable with making requests (n=6).

Other variables affecting routine inquiry identified from the data were the failure to notify requestors of hospital patient deaths and improper completion of request and consent forms. Differences were noted in the implementation of routine inquiry in intensive care units and acute hospital units. Physicians were more frequently involved with requests made in intensive care units. And, physician knowledge and attitudes about anatomical donation affected whether next of kin were requested in some circumstances. Finally, the extent to which families talked with each other about their wishes regarding anatomical donation affected the ease with which next of kin made their decision.