

Paramedic perspectives on organ donation after out-of-hospital cardiac arrest

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ABSTRACT

Background Organ donation after out-of-hospital cardiac arrest (OHCA) remains limited, with most donors identified in hospital settings. Uncontrolled donation after circulatory death (uDCD) offers a potential pathway to expand the donor pool; however, its feasibility in the out-of-hospital environment is unclear, particularly from a paramedic perspective. The aim of this study was to explore operational paramedics' perceptions of organ donation following OHCA and identify barriers and enablers to implementing out-of-hospital uDCD pathways.

Methods Qualitative study using reflexive thematic analysis. Operational paramedics from Australian jurisdictional ambulance services were recruited via purposive and snowball sampling. Participants were registered clinicians authorised for independent practice. Semistructured interviews explored experiences with OHCA, organ donation and uDCD feasibility.

Results Nine paramedics participated (predominantly metropolitan varied experience). Five themes were identified: recognising organ donation opportunities requires experience, clinical judgement and shared decision-making; operational feasibility depends on resources, geography and communication; successful implementation requires integrated systems and organisational support; preparing paramedics and the community for practice change; and balancing ethical responsibilities with patient and family wishes. Organ donation was rarely considered during routine OHCA, although participants most commonly associated donation opportunities with severe intracranial pathology. Decision-making was influenced by cognitive load, team dynamics and clinical experience. Barriers included limited access to donor information, resource constraints, geographic variability and clinician discomfort with end-of-life conversations. Enablers included structured guidelines, early consultation with specialist teams, use of mechanical Cardiopulmonary Resuscitation (CPR) and targeted education. Participants emphasised the importance of separating resuscitation goals from donation processes.

Conclusions Paramedics view organ donation after OHCA as meaningful but complex. Implementation of out-of-hospital uDCD pathways requires clear clinical governance, structured communication processes, integration with hospital and donation services and targeted training. Addressing ethical, logistical and system-level challenges is essential to support safe and acceptable integration into paramedic practice.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Uncontrolled donation after circulatory death (uDCD) has been proposed as one approach to increasing organ donation following out-of-hospital cardiac arrest (OHCA). However, little is known about how operational paramedics perceive their potential role or the practical challenges of implementing these pathways in routine practice.

WHAT THIS STUDY ADDS

⇒ Paramedics recognised the potential value of organ donation following OHCA but consistently described implementation as clinically, operationally and ethically challenging. They identified the need for clear clinical governance, system integration, education and structured communication before out-of-hospital uDCD could be introduced.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ These findings provide an early evidence base to inform future development of out-of-hospital organ donation pathways. They also highlight the importance of multidisciplinary planning, workforce preparation and further research before implementation is considered.

INTRODUCTION

Organ and tissue transplantation offers hope to patients with end-stage organ failure, improving both longevity and quality of life.¹ Each donor has the potential to save up to eight lives, while a tissue donor can positively affect the lives of over one hundred individuals in Australia.² Despite medical advancements and increased awareness campaigns, the demand for organs far outweighs the supply.³ Less than two per cent of the Australian population meets the criteria for donation on death under the current system.²

Organ donation in Australia is governed by state and territory human tissue legislation and coordinated through established hospital-based donation systems. In Australia, the potential for donation is limited to where deaths occur within intensive care units or the emergency department.² This requirement arises from balancing organ viability and ethical and legal benchmarks. Innovative strategies are being explored to expand the donor pool and optimise the organ retrieval process, including



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uncontrolled donation after circulatory death (uDCD) pathways recruited from the out-of-hospital setting.⁴

In 2023, the International Liaison Committee on Resuscitation (ILCOR) published a scientific statement surrounding the implementation and endorsement of uDCD practices.⁵ This recommendation involves donation of organs from individuals who experience sudden cardiac arrest outside of a hospital setting, where resuscitative efforts are either unsuccessful or not initiated.⁶ The inherent constraints of controlled donation after neurological determination of death have motivated the use of alternative avenues, such as uDCD.

The out-of-hospital environment provides a unique perspective for identifying and evaluating potential uDCD donors.⁵ Currently, Australian paramedics do not routinely identify donor eligibility, document or access donor registration status, discuss donation with families or initiate referral pathways; these responsibilities occur after hospital admission through established donation services. Emergency medical services play a crucial role in responding to out-of-hospital cardiac arrests (OHCA) and initiating resuscitation attempts. In instances where resuscitation efforts are unsuccessful, there is an opportunity to identify suitable uDCD donors and initiate the organ retrieval process. Examining the perceptions and experiences of paramedics within this context is important, particularly given the timely and ethical considerations central to organ retrieval.⁷ The concept of uDCD in the out-of-hospital environment is promising, yet it comes with inherent complexities. This research examines the perspectives of operational paramedics regarding organ donation following OHCA and identifies potential barriers to uDCD programme implementation in the Australian EMS.

METHODS

Design and reporting

This study was underpinned by an interpretivist epistemological orientation, recognising that participants' understandings of organ donation following OHCA were shaped by their professional experiences, clinical contexts and interactions within the healthcare system.⁸ This approach enabled exploration of how paramedics understood and interpreted organ donation within the context of everyday out-of-hospital practice. Reflexive thematic analysis was used as the analytic approach within this interpretivist framework.⁹ The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).¹⁰

Research team and reflexivity

The research team comprised (author initials, qualifications and professional roles). Collectively, the team contributed expertise in paramedicine, emergency care, organ donation, qualitative methodology and health professions education. The lead researcher was a specialist paramedic with out-of-hospital research experience. Recognising that prior clinical experience could influence data interpretation, the team adopted a reflexive approach throughout the study. Reflexive field notes and regular team discussions were used to challenge assumptions and ensure themes remained grounded in participants' accounts.¹¹

Setting, sampling and participants

Operational paramedics employed by jurisdictional ambulance services in Australia were recruited using purposive and snowball strategies (professional networks, conference promotion and service-based advertising).¹² Eligible participants were currently registered, working operationally and authorised to practise

independently. No minimum number of OHCA attendances was required. Graduate paramedics and paramedics not employed within jurisdictional ambulance services were excluded.

Data collection

Following written informed consent, semistructured interviews lasting between 45 and 60 min were conducted via Zoom using a guide developed by the research team, refined by two experts in paramedicine, one expert in organ donation, and qualitative research, and piloted with an operational paramedic to assess question clarity and flow before data collection (online supplemental appendix 1). Interviews explored experiences with OHCA, the potential paramedic role in future out-of-hospital donation pathways, perceived feasibility, implementation barriers and enablers and ethical considerations. Interviews were audio-recorded and transcribed verbatim by the lead researcher. Following transcription, identifiers were removed and pseudonyms assigned. Participants were advised that they could pause or withdraw from the interview at any time and were provided with information about available support services if required.

Analysis

Data were analysed using Braun and Clarke's reflexive thematic analysis.⁹ The lead researcher familiarised themselves with the transcripts, generated initial codes inductively and developed themes through iterative review. Themes were reviewed and refined through iterative discussions within the research team to ensure they accurately reflected participants' accounts and remained conceptually distinct. This process emphasised reflexive challenge and interpretive depth rather than inter-rater reliability.⁹

RESULTS

A total of nine participants were interviewed, after the withdrawal of one participant following registration. Victoria was well-represented with six participants, including two from Tasmania and one from South Australia. Six participants operated in metropolitan areas, while three practised in regional settings. Details reflecting expertise and clinical roles are shown in [table 1](#).

Five themes were identified: (1) recognising organ donation opportunities requires experience, clinical judgement and shared decision-making; (2) operational feasibility depends on resources, geography and communication; (3) successful implementation requires integrated systems and organisational support; (4) preparing paramedics and the community for practice change and (5) balancing ethical responsibilities with patient and family wishes. A visual illustration of the themes and their associated subthemes is presented in [figure 1](#).

Table 1 Participant characteristics (n=9)

Characteristic	Category	n (%)
Years of experience	<5 years	3 (33.3)
	5–10 years	2 (22.2)
	10–15 years	1 (11.1)
	15–20 years	2 (22.2)
	>20 years	1 (11.1)
Scope of practice	Advanced life support	6 (66.7)
	Intensive care	3 (33.3)

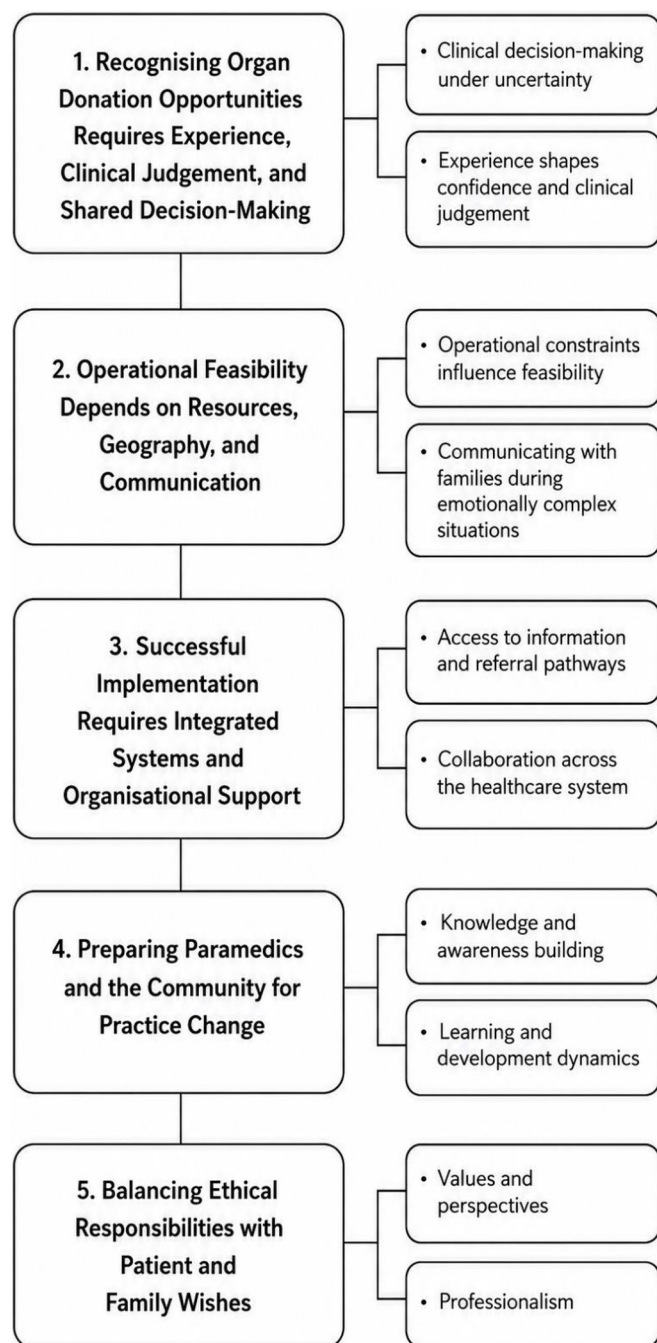


Figure 1 Conceptual framework illustrating the five interpretive themes and associated subthemes describing paramedics' perceptions of organ donation following out-of-hospital cardiac arrest.

Unless otherwise stated, participants' comments regarding uDCC reflected their perceptions of a potential future model rather than current Australian practice.

Theme 1: recognising organ donation opportunities requires experience, clinical judgement and shared decision-making

Participants described recognising potential organ donation opportunities as something that developed through clinical experience, judgement and discussion with colleagues. For many, organ donation was not routinely considered during OHCA, but increasing clinical experience broadened awareness of situations

where donation might be appropriate. Most participants had not previously contemplated organ donation in the context of cardiac arrest: 'Definitely been to a lot of cardiac arrests where we have worked on them for a really long time, but organ donation has never crossed my mind' (P4). However, with extensive clinical experience, instances arose where the prospect of organ donation was genuinely considered: 'I have changed the trajectory of a resuscitation to Cardiopulmonary Resuscitation (CPR) someone to hospital... if we reach medical futility at the health service then organ donation becomes an option' (P8).

Participants identified traumatic intracranial pathology as a pivotal marker for organ donation. 'Probably have some sort of intracranial trauma and then are trending towards a brain death pathway because that means their end organ perfusion should be maintained' (P2). Others considered medical aetiologies: 'I seriously consider anything that's got some kind of brain damage to it, whether it's medically or traumatically caused' (P7).

For the majority, extending resuscitation specifically for organ donation had not been considered. Medical causes of cardiac arrest introduced greater uncertainty, and participants described the need to be selective with patients based on proximity, rhythm, witnessed arrest, bystander CPR, age, fitness and comorbidities. The presence of circulation or ROSC remained central for transport, especially in the absence of familiarity with uDCC programmes. Although some participants described transporting patients to hospital with organ donation in mind, there are currently no Australian data quantifying how frequently this occurs, and published international evidence is similarly limited. These observations, therefore, reflect individual clinical experiences rather than an established or routinely implemented out-of-hospital organ donation pathway.

Clinical decision-making under uncertainty

Many participants described clinical decision-making during OHCA as occurring within an environment characterised by uncertainty, cognitive overload and competing priorities. 'It's such a cognitively overloading environment, and then to add organ donation on top of that, you start to worry like, "am I missing anything in terms of my ALS algorithm?"' (P2). Involvement of several clinicians reduced some cognitive burden through collaborative decision-making: 'somebody within that group of people will hopefully be confident to speak up and say "have you thought about organ procurement?"' [P2].

Participants supported shared decision-making with other healthcare professionals, donation services and receiving hospitals. 'This meets criteria for conversation with a subject matter expert or an organ procurement team... But it shouldn't be up to me as to whether someone is viable for organ donation or not' (P2). Reluctance was noted regarding enrolment without explicit collaboration and endorsement of the receiving healthcare facility.

Experience shapes confidence and clinical judgement

Many participants linked confidence in recognising potential organ donation opportunities with accumulated clinical experience. Junior clinicians were perceived as requiring greater support when making complex end-of-life decisions and communicating with families. Participants felt limited clinical exposure might hamper their capacity to address termination of resuscitation and family conversations. 'I don't think paramedics are very good at end-of-life care for the most part, that comes with time and experience' (P8). Junior clinicians were described as more likely to defer decisions until more experienced staff arrived.

Participants supported clear guidelines to provide direction, streamline decisions and inform when to initiate consultations with medical specialists: 'There should be guidelines in place on who you do and don't take' (P7).

While recognising potential organ donation opportunities was considered the essential first step, participants emphasised that successful implementation would also depend on whether these opportunities could be supported within the operational realities of out-of-hospital care.

Theme 2: operational feasibility depends on resources, geography and communication

Operational constraints influence feasibility

Participants considered the feasibility of introducing out-of-hospital organ donation pathways as highly dependent on operational factors, including geography, resource availability, transport capability and effective communication. Metropolitan participants highlighted the relative simplicity of transferring patients to hospitals, while rural participants described time limitations, equipment accessibility and resource constraints. 'You might be a bit far away from the hospital that can actually harvest organs' (P7). Participants also highlighted the resource-intensive nature of OHCA and the risk of diminishing resources available for other emergencies. Participants considered that introducing a future uDCD pathway would increase the operational complexity of an already resource-intensive response.

A smaller number perceived goal-directed organ preservation as less resource-intensive, given anticipated enrolment numbers. Mechanical CPR devices emerged as an important asset for transport and safety. 'I shouldn't be transporting patients under CPR, if I don't have access to a LUCAS device... CPR is going to be ineffective which means that I'm not sure how good the ability to perfuse organs is going to be' (P2).

Extracorporeal membrane oxygenation (ECMO) is currently undertaking clinical trials within Australian EMS as an adjunctive technique for extended unconventional resuscitation.¹² Some participants perceived value in ECMO where available, but others highlighted challenges in expanding application beyond strict eligibility criteria. Many participants expressed difficulty distinguishing candidates for uDCD and those undergoing unconventional resuscitation.

Communicating with families during emotionally complex situations
Within the context of a potential future Australian out-of-hospital uDCD pathway, participants described the anticipated difficulty of communicating prognosis and initiating organ donation discussions with families after termination of OHCA resuscitation. 'I think people really struggle with even having difficult conversations... we wait for someone else to do it' (P4). Many felt a compassionate and deliberate approach was key, supported by professional confidence and one consistent communicator to reduce ambiguity.

Communication appeared more complex with younger patients, with difficulties and distress for grieving families and paramedics. Participants highlighted the importance of structured communication frameworks, scripts or keywords when interacting with grieving families. 'You don't want to get their hopes up to say that we're continuing because we think that they'll have a chance, its 'we're continuing for a different purpose now' [P3].

Junior paramedics expressed discomfort initiating such conversations and described a need for support. In contrast, senior paramedics advocated for junior paramedics to be guided

through these conversations, emphasising increased exposure and learning to navigate discomfort.

Participants recognised that operational challenges alone would not determine the success of an out-of-hospital organ donation pathway. They also described the need for coordinated organisational systems capable of supporting clinical decision-making and continuity of care.

Theme 3: successful implementation requires integrated systems and organisational support

Access to information and referral pathways

Participants believed that successful implementation would depend on coordinated system design, including clear referral pathways, organisational support, access to donor information and collaboration between ambulance services, hospitals and organ donation agencies. In the setting of uDCD, organ viability diminishes, focusing primarily on kidneys, liver and tissue.¹³ Participants felt there could be advantages in reducing transplant waitlists and dialysis demand.¹⁴ However, some described variation in organ value, with kidneys perceived as having less practical significance than heart and lungs.

Collaboration across the healthcare system

In Australia, the current organ donation system requires preregistration or family consent for organ retrieval.¹⁴ Participants discussed donor registration within the context of a hypothetical future out-of-hospital uDCD pathway rather than existing paramedic practice. Participants emphasised complexities when definitive documentation was absent, highlighting the need for a streamlined approach or enhanced public education regarding organ donation preferences. 'I think opt-out works well, but I think there's a lot of legal and ethical issues in Australia because of the opt-in' (P7).

Limited access to health records and donor registration information was a significant barrier. Participants suggested links to donor registries, MyHealth record or hospital-based information to confirm preferences and contraindications. Without this information, conversations about organ donation with family members become more complex.¹⁵

Alongside system redesign, participants repeatedly identified education as essential if paramedics and the community were to understand and accept an expanded role in organ donation following OHCA.

Theme 4: preparing paramedics and the community for practice change

Knowledge and awareness building

Participants distinguished between education aimed at improving public understanding of organ donation and profession-specific education required to prepare paramedics for a future out-of-hospital uDCD pathway. An informed community, aware of potential paramedic involvement in end-of-life organ donation processes, could improve communication for paramedics and families. 'If they're aware that the conversation could come up, then maybe it makes it less surprising and more of an informative situation' (P4).

Many participants felt that, because they frequently encountered death and dying, they held a position to educate on post-mortem opportunities. Their frontline experiences with death, combined with medical expertise, made them well placed to inform, guide and support families.⁴

Learning and development dynamics

Within the out-of-hospital healthcare setting, postmortem opportunities have historically been outside routine practice;

however, paramedics suggested specialised training programmes. This training should include difficult conversations and end-of-life conversations, with interactive sessions led by subject matter experts in organ donation and associated ethical dimensions.¹⁶ 'It's going to have to be extensive education. Like the whys, the how's, the who's... also probably have training in difficult conversations' (P7).

Although education was considered essential, participants emphasised that any future programme must also be grounded in strong ethical principles that respected patients, families and professional responsibilities.

Theme 5: balancing ethical responsibilities with patient and family wishes

Values and perspectives

Participants described balancing ethical responsibilities with respect for patient autonomy, family wishes and professional obligations as central to any future implementation of out-of-hospital organ donation pathways. Although views differed, participants emphasised respecting and upholding the desires of individuals and families. 'Everybody's ethics are theirs, and if we are following the wants and wishes and clear desires of the individual, I think this makes it much less ethically challenging' (P8).

Where patient or family preferences were uncertain, paramedics displayed varied ethical stances on continuing efforts for organ preservation and subsequent evaluation. Some described discomfort, while others would err towards preservation where more people could be saved.

Participants described apprehension regarding organ donation conversations, emphasising the delicate and difficult nature of these conversations.¹⁷ These discussions are reinforced by time-sensitive and emotive environments after sudden cardiac arrest.⁵ Concerns included finding the right words, professional confidence, bias, cultural assumptions, and the profound grief of bereaved families.

Professionalism

Participants distinguished ethical values from professional standards. Some felt organ donation could be accepted as part of their role if it was the best thing for the patient, family and recipients. Participants also expressed concern about prematurely commencing a donation pathway and compromising patient care. 'We are focused on an outcome until we achieve futility, and then we are focused on a new outcome' (P8).

DISCUSSION

The findings demonstrate that paramedics regarded organ donation after unsuccessful OHCA as clinically meaningful but operationally and ethically complex. This study examined how operational paramedics perceived organ donation after OHCA and the feasibility of future out-of-hospital uDCD pathways. Participants viewed organ donation as meaningful, provided resuscitation decisions remained clearly separated from any subsequent donation pathway once medical futility had been established.

A key finding was that organ donation rarely enters routine paramedic decision-making in OHCA, except where intracranial injury is suspected.⁵ This appears to reflect both clinical reasoning strategies and the cognitive burden of managing high-stakes resuscitation. Participants described the value of shared decision-making and early consultation with donation specialists and receiving hospitals to reduce uncertainty.¹⁸

Metropolitan participants perceived fewer barriers to transport and hospital access, while regional participants highlighted distance to retrieval-capable centres and limits in advanced options, including ECMO.⁵ Mechanical CPR was identified for sustaining perfusion during transport and clinician safety; however, participants were clear that resource diversion and costs must be considered within constrained EMS systems.¹⁹

Communication and consent were also described as challenges. Participants anticipated that discussions with families immediately after unsuccessful resuscitation would be difficult, particularly for junior clinicians and in paediatric deaths. Several participants recommended structured conversation supports to maintain compassion and protect public trust.^{17 20} Consistent with these concerns, participants emphasised the ethics of uDCD as dependent on respecting patient wishes and family preferences.⁷ Consistent with these concerns, participants emphasised that any future out-of-hospital uDCD pathway must maintain public trust by ensuring that resuscitation decisions remain independent of donation decisions and continue to respect patient wishes and family preferences. Limited access to donor registration information and health history would complicate timely decisions; participants, therefore, favoured system-level solutions rather than leaving candidacy decisions to paramedics.²¹ While this study focused on paramedic perspectives, successful implementation would also require engagement with emergency physicians, intensive care clinicians, donation specialists, policy-makers and families, whose perspectives may differ from those reported here. These findings are consistent with international recommendations that emphasise clear clinical governance, coordinated referral pathways, multidisciplinary collaboration and communication training to support implementation of out-of-hospital uDCD pathways.^{5 6 16}

These findings indicate that any Australian out-of-hospital uDCD model would require: explicit clinical governance clarifying when a donation pathway can be considered; reliable consultation and referral mechanisms with donation services and receiving hospitals; training focused on end-of-life communication, ethics and role boundaries; resourcing that protects clinician safety and minimises impacts on community coverage; participants also perceived that public education may improve understanding and acceptance of future donation conversations.

Future studies should also explore whether paramedics believe all patients experiencing OHCA should receive equivalent resuscitative effort irrespective of potential organ donation, as this emerged as an important ethical consideration but was not explored directly within the interview questions.

Limitations

This study was geographically limited to the Southeast corner of Australia, which limits generalisability. Differences in paramedic practice and experience across cultural and operational contexts suggest that findings may not be directly transferable to other jurisdictions. Although participants contributed rich and information-rich accounts from diverse operational contexts, the findings reflect the experiences of this particular group of paramedics and should not be interpreted as representing all Australian paramedics. The recruitment approach may have resulted in greater participation from paramedics with an existing interest in organ donation. Recall bias, social desirability bias and interviewer effects may also have shaped responses.

CONCLUSION

This study suggests participating paramedics viewed organ donation following unsuccessful resuscitation as meaningful, although implementation was considered complex and requires further evaluation. Ethical and moral challenges highlight the need for further research before integration into routine paramedic practice. Addressing these issues will be important before organ donation can be incorporated into routine paramedic practice.

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